Enrollment/Change Request

Aetna U.S. Healthcare®

Employer Group Information - To Be Completed by Employer

Group Name	Group Number	Class Code

A. Type of Activity - To Be Completed by Employer *Refer to instructions on back before completing this form. Print clearly.*

1. Enrollment

☐ New Enrollee/Subscriber

Effective Date ___/___/___

Date of Hire ___/___/___

2. Change - *Check all that apply.*

	Date of Event	Reason
☐ Add Spouse	/ /	
☐ Add Dependent Child	/ /	
☐ Name Change	/ /	
☐ Change Plan	/ /	
☐ Other	/ /	
☐ Add/Change Primary Office / Primary Dentist (if applicable)		

3. Termination - *Check all that apply.*

	Effective Date	Reason
☐ Remove Spouse	/ /	
☐ Remove Dependent Child	/ /	
☐ Withdrawal/Termination	/ /	

4. Continuation of Coverage, i.e., COBRA, State

Coverage For: ☐ Employee ☐ Dependents

Length of Continuation: ☐ 18 ☐ 36 ☐ Other ____

☐ 29 - Attach disability determination from the Social Security Administration

Date of Loss of Coverage: ___/___/___

Date of Qualifying Event: ___/___/___

B. Employee Information - Complete Sections B - G.

Social Security Number	Last Name, First Name, M.I.		Home Telephone ( )
Home Address	Apt. No.	City, State	ZIP Code
Employer Name			Work Telephone ( )
Work Address		City, State	ZIP Code

C. Plan Option - Your selection must be offered by your employer.

Check One:

☐ HMO ☐ QPOS® ☐ USAccess®

☐ Aetna Open Access™ HMO

______ Indicate Plan Name

Primary Copay: ☐ \$0 ☐ \$2 ☐ \$5 ☐ \$10 ☐ \$15 ☐ Other \$ ____

Individual Deductible Amount - For QPOS Plans Only

☐ \$100 ☐ \$200 ☐ \$250

☐ \$300 ☐ \$400 ☐ \$500

☐ \$750 ☐ \$1,000 ☐ Other \$ ____

D. Individuals Covered - List individuals for whom you are electing/changing coverage. Attach sheet to list additional children. Attach proof if full-time college student.

	(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex M F	Birthdate MM DD YYYY	Social Security Number	Other Health Coverage	Other Rx Drug Coverage	Primary Office ID Number	Current Patient	Dentist Office ID Number (If applicable)	Current Patient	Race/Ethnicity - Optional (This information is designed for the purpose of data collection and will not be used for determining eligibility, rating or claim payment.)
Employee			☐ ☐	/ /		Yes ☐	Yes ☐		Yes ☐		Yes ☐	☐ White - 01 ☐ African American or Black - 02 ☐ Hispanic or Latino - 03 ☐ Asian - 04 ☐ Other - 05 ____
Spouse			☐ ☐	/ /		☐	☐		☐		☐	☐ White - 01 ☐ African American or Black - 02 ☐ Hispanic or Latino - 03 ☐ Asian - 04 ☐ Other - 05 ____
Child			☐ ☐	/ /		☐	☐		☐		☐	☐ White - 01 ☐ African American or Black - 02 ☐ Hispanic or Latino - 03 ☐ Asian - 04 ☐ Other - 05 ____
Child			☐ ☐	/ /		☐	☐		☐		☐	☐ White - 01 ☐ African American or Black - 02 ☐ Hispanic or Latino - 03 ☐ Asian - 04 ☐ Other - 05 ____
Child			☐ ☐	/ /		☐	☐		☐		☐	☐ White - 01 ☐ African American or Black - 02 ☐ Hispanic or Latino - 03 ☐ Asian - 04 ☐ Other - 05 ____

E. Other Insurance

Is your Spouse Employed? ☐ Yes ☐ No If "Yes," provide name and address of spouse's employer.

If you have checked "Yes" to Other Health Coverage (Section D), provide name and policy number of insurance carrier, HMO, or other source.

If you have checked "Yes" to Other Rx Drug Coverage (Section D), provide name and policy number of insurance carrier, HMO, or other source.

F. Dependent Information

Does any dependent listed in Section D live at a different address than the Employee? ☐ Yes ☐ No If "Yes," who and what address?

Explain the circumstances.

If any dependent's last name differs from yours, explain the circumstances.

G. Employee Signature *If you have questions concerning the benefits and services provided by or excluded under this Agreement, contact a Member Services representative at 1-800-323-9930 before signing this form.*

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the reverse side of the employee copy of this application.

Employee Signature X

Date / / E-Mail Address

If available, are you interested in plan materials in Spanish? ☐ Yes ☐ No

H. Employer Verification - To Be Completed by Employer

Employer Signature X

Title Date / /

Employee copy may be used as a temporary ID card for 30 days from the effective date if authorized by employer. Coverage must be verified with Aetna U.S. Healthcare prior to visiting a specialist or admission to a hospital.

GR-67757 (3-01)

Make a copy for your records. **visit us at www.aetna.com**

CT, DC, DE, IN, KY, MA, MI, NV, NY, OH, TN

(V1) **R-POD** © 2001 Aetna U.S. Healthcare Inc.

Instructions

Employer

- Complete the **Employer Group Information** in the upper right corner of the form.
- **Section A - Type of Activity:** Check box(es) indicating reason(s) for submitting application.
- Complete **Section H - Employer Verification** in the lower right corner of the form.
  - Employer must complete this section for all new enrollments or coverage changes.
  - Employer must sign and date the application in order for it to be processed.

Employee - Complete Sections B - G.

Section B - Employee Information:
Complete **all** information in order for your application to be processed.

Section C - Plan Option:
- Check one Plan Option box, indicate Plan Option Name (where applicable) and check *one* Primary Copay and/or Individual Deductible Amount (if applicable).
- Select only an option offered by your employer.

Section D - Individuals Covered:
- Add/Change/Remove - Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
- If a dependent is a full-time college student, you **must** attach a current course schedule or a letter from the school confirming full-time student status (12 or more credits).
- If you or your dependent(s) have other Health or Rx drug coverage, check off the "Yes" box(es) and complete Section E - Other Insurance.
- From the appropriate provider directory, locate the **6-digit** office ID number for the primary care physician and/or dentist (if applicable). Indicate office ID number selection(s) on the form.
- If you are a current patient, please check the "Current Patient" box.
- *Optional* - Indicate the Race/Ethnicity for yourself and your dependents by checking the appropriate box(es). If your Race/Ethnicity is other than the selections listed, please check the "Other" box and print the Race/Ethnicity for yourself and your dependents in the space provided.

Section E - Other Insurance:
Complete this section for all new enrollments or coverage changes.

Section F - Dependent Information:
Complete this section for all new enrollments or coverage changes.

Section G - Employee Signature:
- Complete this section for all new enrollments or coverage changes.
- Employee must sign and date the application in order for it to be processed.

Section H - Employer Verification:
- Employer must complete this section for all new enrollments or coverage changes.
- Employer must sign and date the application in order for it to be processed.

Conditions of Enrollment

Applicant Acknowledgments and Agreements

On behalf of myself and the dependents listed on the reverse side, I agree to or with the following:

1. I acknowledge that by enrolling in an Aetna U.S. Healthcare plan, coverage is provided by Aetna U.S. Healthcare and/or affiliated insurance company (Corporate Health Insurance™ Company or U.S. Health Insurance Company).
2. Enrollment of myself and of the listed dependents into the plan is effective on acceptance by Aetna U.S. Healthcare.
3. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. My employer is hereby authorized to withhold payments from my wages as appropriate.
4. As a condition of coverage, I understand and agree that referred benefits (with the exception of emergency procedures and certain direct access services as defined in the plan documents) all services, in order to be covered by Aetna U.S. Healthcare, must be performed either by a participating primary care physician, or by the participating specialist, hospital, pharmacy, dentist, or other provider as authorized by a referral from a participating primary care physician*.
5. I agree to make copayments, as provided for in my plan documents, directly to providers of health care.
6. I understand that Aetna U.S. Healthcare considers member health information private and confidential and has policies and procedures in place to protect it against unlawful use and disclosure. In addition, the providers, vendors, and consultants who help Aetna U.S. Healthcare administer its health benefits plans are required by contract to keep member information confidential, consistent with applicable law. Providers also must give members access to their medical records at any time. Aetna U.S. Healthcare discloses member health information to providers (doctors, pharmacies, hospitals and other providers and facilities), payors (including self-funded plan sponsors), vendors, consultants, and government authorities with jurisdiction - and use the information internally - when necessary for my care or treatment, operation of my health plan, or to conduct related activities. For example, Aetna U.S. Healthcare uses and discloses health information to administer benefits policies and contracts (which may include activities like claims payment, utilization review and management, medical necessity review, coordination of care, benefits, and other services, auditing, anti-fraud activities, plan-related analysis and reporting, and others described below); operate preventive health, early detection, and disease and case management programs; perform quality assessment and improvement activities; conduct performance measurement, outcomes assessment, and health claims analysis and reporting; manage our data and information systems; comply with legal or regulatory requirements; conduct litigation and similar proceedings; transition policies and contracts to or from other insurers, HMOs, and third party administrators; and facilitate due diligence proceedings in connection with the purchase or sale of benefits plans. By enrolling in the plan, I authorize these uses and disclosures on behalf of myself and my listed dependents. I acknowledge that I or an individual entitled to act on my behalf, am entitled to receive a copy of this authorization upon request, and that a photocopy is as valid as the original.
7. The plan documents will determine the rights and responsibilities of member(s) and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
8. I authorize the substitution of generic pharmaceuticals for the brand-name products, as provided by law, for prescriptions filled under any pharmacy benefit.
9. I understand that this coverage will remain in effect until my employer's next open-enrollment period regardless of the continued availability of a particular primary care physician or other health care provider.
10. I acknowledge that Aetna U.S. Healthcare's participating providers, including all participating primary care physicians, are independent contractors and are neither agents nor employees of Aetna U.S. Healthcare.

* *Some services may require prior authorization from Aetna U.S. Healthcare. Certain plans only provide coverage for referred benefits.*

Your enrollment in Aetna U.S. Healthcare and accessing of your benefits signifies your agreement to these conditions, which are subject to change.

Misrepresentation

11. Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Aetna U.S. Healthcare is a for-profit HMO.