New York Small Group Business (2 - 50 Eligible Employees)
Employee Enrollment/Change Form

Aetna®

Member Aetna ID Number (if available)

Employer Name

INSTRUCTIONS: You, the employee, must complete this enrollment form in full or it will be returned to you resulting in a delay in processing. You are solely responsible for its accuracy and completeness. **If waiving coverage, please complete Sections B and E.**

Effective Date

Date of Hire

☐ New Hire ☐ Late Enrollment
☐ Rehire/Reinstatement ☐ Other _____
☐ New Group Enrollment

☐ Change of Coverage
☐ Add Spouse/Dependent Child
☐ Name Change ☐ Other _____

☐ Employee Termination
☐ Remove Spouse/Dependent Child
☐ Cancel Coverage

COBRA/State Continuation for:
☐ Employee ☐ Dependent
Length of Continuation:
☐ 18 ☐ 36 ☐ Other _____
Original Qualifying Event Date _____
Reason _____

A. Coverage Selection - *Please print clearly, using black ink.* *(Shaded sections for Employer/Aetna Use Only)*

Control/Group No.	Suffix	Account	Plan No.	Class Code	Control/Group No.	Suffix	Account	Plan No.	Control/Group No.	Suffix	Account	Plan No.

1. Medical - Check one.
☐ HMO Open Access - 20
☐ POS Open Access - 20
☐ POS Open Access - 21
☐ POS Open Access - 22
☐ EPO Open Access (please check one): ☐ 1 ☐ 2
☐ Indemnity - 20
☐ Managed Choice Open Access - 21
☐ Managed Choice Open Access - 22
☐ Managed Choice First Dollar - 23
☐ Managed Choice Open Access (please check one): ☐ 24 ☐ 25 ☐ 26 ☐ 27 ☐ 28 ☐ 29

2. Dental - Check one.
☐ HMO Rider Option 1
☐ Option 2
☐ Option 3: DMO ___ *or* PPO ___
☐ Option 4 ☐ Option 5 ☐ Option 6

Before today, were you covered under this employer's dental plan? ☐ Yes ☐ No

3. Life
☐ Basic Life / AD&D Ultra™
☐ Optional Dependent Life
☐ Life & Disability Packaged Plan

Beneficiary Designation - **Full Name** (First, Middle, Last)

Beneficiary Social Security No. | Relationship to Employee

B. Employee Information - *Must be completed by the employee.*

Social Security Number	Last Name, First Name, M.I.		Job Title	Home Telephone	*Primary Language Spoken (Optional)*
Home Address		Apt. No.	City, State		ZIP Code
Work Address		City, State		ZIP Code	Work Telephone
Salary (required) $ ☐ Hourly ☐ Weekly ☐ Monthly		No. of Hours Worked Per Week	Check One ☐ Part-time ☐ Full-time	Marital Status ☐ Married ☐ Single	No. of Dependents Including Spouse

C. Individuals Covered - *List individuals for whom you are enrolling or adding/changing/removing coverage. Insert additional sheets if necessary. Height and weight information needed for Life Insurance applicants only.*

Name (Last, First, M.I.)	Sex M/F	Social Security No.	Birthdate MM / DD / YYYY	Height (ft., in.)	Weight (lbs.)	Incapacitated	Coverage Election	Other Health Coverage	Other Dental Coverage	Student Age 19 or Older	Out of Area	Primary Office ID Number (If applicable)	Current Patient	Dental Office ID Number (If applicable)	Current Patient
Employee 1.			/ /			Yes N/A	☐ Medical ☐ Dental ☐ Life	Yes ☐	Yes ☐	Yes N/A	Yes ☐		Yes ☐		Yes ☐
Spouse 2.			/ /			N/A	☐ Medical ☐ Dental ☐ Life	☐	☐	N/A	☐		☐		☐
Child 3.			/ /			☐	☐ Medical ☐ Dental ☐ Life	☐	☐	☐	☐		☐		☐
Child 4.			/ /			☐	☐ Medical ☐ Dental ☐ Life	☐	☐	☐	☐		☐		☐

D. 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 1. ☐ White - 01 ☐ African American or Black - 02 ☐ Hispanic or Latino - 03 ☐ Asian - 04 ☐ Other - 05 _____

Spouse 2. ☐ White - 01 ☐ African American or Black - 02 ☐ Hispanic or Latino - 03 ☐ Asian - 04 ☐ Other - 05 _____

Child 3. ☐ White - 01 ☐ African American or Black - 02 ☐ Hispanic or Latino - 03 ☐ Asian - 04 ☐ Other - 05 _____

Child 4. ☐ White - 01 ☐ African American or Black - 02 ☐ Hispanic or Latino - 03 ☐ Asian - 04 ☐ Other - 05 _____

E. Declination/Waiver of Coverage - *To be completed if medical and/or dental coverage is declined or refused by an eligible employee and/or their eligible family members.*

1. Medical Coverage Declined for:
☐ Myself ☐ Spouse ☐ Dependents

2. Dental Coverage Declined for:
☐ Myself ☐ Spouse ☐ Dependents

Reason for Declining Coverage *(If applicable, please attach front/back of your health coverage ID card.)*:
☐ Covered by spouse's group coverage - Carrier Name and ID _____
☐ Enrolled in other Insurance Plans - Insurance Company Name and ID _____
☐ Medicare ☐ Covered by TRICARE or CHAMPVA ☐ Other (Explain): _____
☐ Spouse covered by employer's group medical coverage ☐ Spouse covered by employer's group dental coverage

I acknowledge I have been given the right to apply for this coverage, however, I am electing not to enroll. By declining this group coverage I acknowledge that myself and/or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage. Pre-existing conditions, when enrolled in this plan, may not be covered for twelve months.

Please sign here ONLY IF YOU ARE DECLINING coverage for yourself or dependent(s). | ***Date (Month / Day / Year)***

X Employee Signature

F. Dependent Information

Does any dependent listed in Section C live at another address? If Yes, who and what address? ☐ Yes ☐ No	If any dependent's last name differs from yours, explain the circumstances.

G. Other Insurance

If you have checked "Yes" to Other **Health** Coverage (Section C), provide name and policy number of insurance carrier, HMO, or other source; a copy of the insurance card, and the start date of coverage.

*If you have checked "Yes" to Other **Dental** Coverage (Section C), provide name and policy number of insurance carrier, HMO, or other source; a copy of the insurance card,* and the start date of coverage.

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

PROOF OF PRIOR COVERAGE - IMPORTANT *(Required)*

Does anyone enrolling on this enrollment form have prior coverage?

☐ Yes ☐ No If you answered "yes", provide applicant names, start and end dates of prior coverage.

_____

_____

_____

_____

_____

_____

Proof of coverage must accompany this enrollment form for pre-existing condition credit.

Acceptable forms of proof are:

1. Certificate of Creditable Coverage from prior carrier, or
2. Copy of ID card or most recent payroll stub showing medical coverage deduction, or
3. Copy of most recent medical premium bill from prior carrier.

Failure to provide Proof of Prior Coverage may subject you or a family member to the full pre-existing conditions limitation with no credit for prior coverage. You may request a Certificate of Creditable Coverage from your prior carrier.

Conditions of Enrollment

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 the following plans, coverage is provided by the following entities (collectively referred to as "Aetna"):
   - Aetna Primary Care Plan HMO and Aetna Choice Plan POS and Dental HMO Rider: Aetna Health Inc. and/or Corporate Health Insurance Company
   - Aetna Managed Choice Plan PPO: Aetna Life Insurance Company
   - Life, Accidental Death & Dismemberment, DMO, Dental PPO and all other coverages: Aetna Life Insurance Company
2. I understand and agree that my employer's application will determine coverage and that there is no coverage unless and until both the eligible employee and employer applications have been accepted and approved by Aetna. Even if this enrollment form is approved, any misstatements or omissions may result in future claims being denied and the policy or my coverage under the policy being rescinded or reevaluated, as of the effective date, for eligibility and rating purposes.
   For life coverages: I understand that the effective date of insurance for myself or for any of my dependents is subject to my being actively at work on that date and that the effective date of insurance for any of my dependents is also subject to the dependent health condition requirements of the benefit plan. Further, I understand that any insurance subject to evidence of good health or medical information will not become effective until Aetna gives its written consent.
3. I understand and agree that this enrollment form may be transmitted to Aetna or its agent by my employer or its agent. I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("Providers") to give to Aetna or its agent information concerning the medical history, services or treatment provided to anyone listed on this enrollment form, including those involving mental health, substance abuse and HIV/AIDS. I further authorize Aetna to use such information and to disclose such information to affiliates, providers, payors, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. I have discussed the terms of this authorization with my spouse and competent adult dependents, and I have obtained their consent to those terms. I understand that this authorization is provided under state law and that it is not an "authorization" within the meaning of the federal Health Insurance Portability and Accountability Act. This authorization will remain valid for the term of the coverage and for so long thereafter as allowed by law. I understand that I am entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original.
4. 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.
5. I understand and agree that, with the exception of Aetna Rx Home Delivery, all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.
6. I understand and agree that, with certain exceptions described in the plan documents, HMO and DMO plans only provide coverage for referred benefits, and that, in order to be covered, services must be performed either by a participating primary care physician, primary care dentist, or by the participating specialist, hospital, pharmacy, dentist, or other provider as authorized by a referral from a participating primary care physician.
7. I understand and agree that, as described in the plan documents and when enrolled for medical coverage, any pre-existing conditions for my spouse, dependents or myself may not be covered for 12 months.

Misrepresentation

8. Any person who knowingly and with intent to defraud 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I represent that all information supplied in this form is true and complete. I have read and agree to the Conditions of Enrollment and Misrepresentation on this New York Small Group Business (2 - 50 Eligible Employees) Employee Enrollment/Change Form. I understand that, in the event I fail to sign this form within 31 days after the above transaction request or for any reason Aetna does not receive notice of the above transaction request within a reasonable time following the event, my and my dependents' eligibility may be affected. I am employed by the employer shown on Page 1, and I am working full time at least 20 hours per week for this employer at the regular place of business.

Employee Signature	*Employee E-mail Address (optional)*	*Date (Mo./Day/ Yr)*
X		
Employer Signature		*Date (Mo./Day/ Yr)*
X		