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

☐ **Aetna Life Insurance Company**
151 Farmington Avenue
Hartford, CT 06156

☐ **Aetna Health Inc.**
1425 Union Meeting Road
Blue Bell, PA 19422

☐ **Aetna Health Insurance Company of New York**
333 Earle Ovington Blvd., Suite 104
Uniondale, NY 11553

Life, Accidental Death & Dismemberment, Aetna EPO plans, Aetna Indemnity, and Aetna Managed Choice Plan PPO are provided by Aetna Life Insurance Company. Aetna Primary Care Plan HMO, Aetna QPOS, and Aetna NYC Community Plan℠ are provided by Aetna Health Inc. and Aetna Health Insurance Company of New York. DMO and PPO dental plans are provided by Aetna Life Insurance Company.

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 D.**

Effective Date

Date of Hire

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

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

☐ Employee Termination
☐ Remove Spouse/Domestic Partner/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

1. Medical - Check one.

Managed Choice Open Access:

☐ 21a-07	☐ 21b-07	☐ 21c-07	☐ 22a-07
☐ 22b-07	☐ 22c-07	☐ 24-08	☐ 24b-07
☐ 24c-07	☐ 26a-07	☐ 26b-07	☐ 26c-07
☐ 27-07	☐ 29a-07	☐ 29b-07	☐ 29c-07
☐ 33a-07	☐ 33b-07	☐ 33c-07	

Managed Choice Open Access (HSA Compatible):

☐ 30-07	☐ 31-07	☐ 34-07	☐ 35-08

EPO Open Access:

☐ 1b-08	☐ 1c-08	☐ 2a-07	☐ 2b-07
☐ 2c-07	☐ 3-08	☐ 3b-07	☐ 3c-07
☐ 4-08	☐ 4b-07	☐ 4c-07	

NYC Community Plan℠

☐ 1D -07	☐ 2-07	☐ 3D-07	☐ 4-07

Indemnity:
☐ 20-07

Control/Group No.	Suffix	Account	Plan No.

2. Dental - Check one.

Standard Plans:
☐ Option 2: DMO
☐ Option 3: Freedom of Choice: ☐ DMO *or* ☐ PPO
☐ Option 4: PPO Max
☐ Option 5: Active PPO
☐ Option 6: Passive PPO
☐ Option 7: Consumer Directed
☐ Option 8: Freedom of Choice: ☐ DMO *or* ☐ PPO
☐ Option 9: PPO 2000
☐ Out-of-State PPO Plan

Voluntary Plans:
☐ Option 2: DMO
☐ Option 3: Freedom of Choice: ☐ DMO *or* ☐ PPO
☐ Option 4: PPO Max
☐ Out-of-State PPO Plan

Control/Group No.	Suffix	Account	Plan No.

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

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

Beneficiary Social Security Number

Relationship to Employee

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

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

No. of Hours Worked Per Week	Check One	Marital Status	No. of Dependents Including Spouse/Domestic Partner
	☐ Full-Time ☐ Part-Time	☐ Married ☐ Single	