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 Number	Birthdate (MM/DD/YYYY)	Coverage Election	Other Health Coverage	Other Dental Coverage	Prior 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.				☐ Medical ☐ Dental ☐ Life/Dis	Yes ☐	Yes ☐	Yes ☐	Yes N/A	Yes N/A		Yes ☐		Yes ☐
Spouse/Domestic Partner 2.				☐ Medical ☐ Dental ☐ Life	☐	☐	☐	N/A	N/A		☐		☐
Child 3.				☐ Medical ☐ Dental ☐ Life	☐	☐	☐	☐	☐		☐		☐
Child 4.				☐ Medical ☐ Dental ☐ Life	☐	☐	☐	☐	☐		☐		☐

D. 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/Domestic Partner ☐ Dependents
2. **Dental Coverage Declined for:**
   ☐ Myself ☐ Spouse/Domestic Partner ☐ Dependents

Reason for Declining Coverage *(If applicable, please attach front/back of your health coverage ID card.)*:

☐ Covered by spouse/domestic partner's group coverage - Carrier Name and ID _____

☐ Enrolled in other Insurance Carrier Plans - Carrier Name and ID _____

☐ Medicare ☐ Covered by TRICARE or CHAMPVA ☐ Other _____

☐ Spouse/Domestic Partner covered by employer's group medical coverage

☐ Spouse/Domestic Partner 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 and/or dependent(s). | ***Date (Month/Day/Year)***

X **Employee Signature**

E. Dependent Information

Does any dependent listed in Section C live at another address? ☐ Yes ☐ No
If Yes, who and what address?

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

F. 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/Domestic Partner employed? ☐ Yes ☐ No If "Yes," provide name and address of spouse/domestic partner's employer.

PROOF OF PRIOR COVERAGE - IMPORTANT *(Required for other than Life Insurance)*

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 or waiver of dental waiting period.

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, Aetna QPOS, and Aetna NYC Community Plan℠: Aetna Health Inc. and Aetna Health Insurance Company of New York
   - Aetna Managed Choice Plan PPO: Aetna Life Insurance Company
   - Life, Accidental Death & Dismemberment, DMO, Dental PPO and all other health coverages: Aetna Life Insurance Company

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