



We would like to walk you through some common areas of confusion when filling out the Enrollment/Change form.

During this presentation, we are using the form shown below on the left. The forms you use may look different. The information shown here will generally be the same from one form to another.

Let's look at the Employer Name first.

The Employer Name is used to indicate the name of the company that the employee works for.

The employee's name does not belong in this field. On most forms, the employee's name is not placed in the first section.

Next let's look at the Date of Hire.

The Date of Hire is important because it is used to determine the effective date of the employee. A missing or incorrect date can have a negative impact on the employee's coverage or the premiums.

If the Date of Hire is missing, the form may be returned, thereby causing a delay in the enrollment process.

Another important part of the enrollment form is the plan/coverage selection.

There are three common categories within this section of the form: Medical, Dental, and Life & Disability.

It is important for the proper plan choices to be made. If the correct information is not provided here, it may result in incorrect premiums or benefits, or it may result in a delay of services, such as a Doctor visit.

Another important part of the form is the birthdate.

The Birthdate is a very important field that must be completed on the enrollment form. This includes the dates of birth for the employee and for any dependents.

If the date of birth is missing, the employee and/or dependents cannot be entered into the system. If an incorrect date of birth is provided, it can affect premiums, eligibility, and/or claims payments.

The employee's Social Security Number goes here.

A member must have a Social Security Number to be enrolled in the system.

If it is missing, a phone call will be made or the enrollment form will be returned. Both will cause a delay in the enrollment process.

If this box is signed, the employee will not receive benefits.

Aetna California Small Group Business (2 - 50 Eligible Employees) Employee Enrollment/Change Form

Applicant's Social Security Number: _____

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: New Group Enrollment Late Enrollment Add Spouse/Dependent Child Employee Termination COBRA/Cal-COBRA for: Employee Dependent

Date of Hire: New Hire Other Change of Coverage Remove Spouse/Dependent Child Length of Continuation: 18 36 Other _____

Plan Reinstatement Name Change Other Cancel Coverage 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.	Control/Group No.	Suffix	Account	Plan No.	Control/Group No.	Suffix	Account	Plan No.
1. Medical - Check one.			2. Dental - Check one (if applicable).			3. Life					
<input type="checkbox"/> Aetna HMO Plan - Plan Option _____			<input type="checkbox"/> Option 1 _____			<input type="checkbox"/> Basic Life / AD&D Ultra™					
<input type="checkbox"/> Aetna MC Plan - Plan Option _____			<input type="checkbox"/> Option 2: <input type="checkbox"/> DMO or <input type="checkbox"/> PPO			<input type="checkbox"/> Optional Dependent Life					
<input type="checkbox"/> Aetna High Deductible MC Plan _____			<input type="checkbox"/> Option 3 <input type="checkbox"/> Option 4			Beneficiary Designation - Full Name (First, Middle, Last) _____					
<input type="checkbox"/> Aetna EPO Plan _____			<input type="checkbox"/> Option 5 <input type="checkbox"/> Option 6			Beneficiary Social Security No. _____ Relationship to Employee _____					
<input type="checkbox"/> Aetna PPO Plan - Plan Option _____			<input type="checkbox"/> Out-of-State _____			Before today, were you covered under this employer's dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<input type="checkbox"/> Aetna Indemnity _____											
<input type="checkbox"/> Aetna PPO Out-of-State Plan _____											

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

Member Aetna ID Number (if available) _____ 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 Per Week 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.
NOTE: Enter Domestic Partner ONLY if your employer has elected that coverage.

Age Group (Options)	Name (Last, First, M.I.)	Sex	Social Security No.	Birthdate	Height (ft. in.)	Weight (lbs.)	Incapacitated	Coverage Election	Other Health Coverage	Student Age 19 or Older	Primary Office Number (if applicable)	Dental Office ID Number (if applicable)	Current Patient
Employee	1.	M/F	MM/DD/YYYY	MM/DD/YYYY			<input type="checkbox"/> Yes <input type="checkbox"/> N/A	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Spouse/Domestic Partner	2.						<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Child	3.						<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Child	4.						<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

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

2. Dental Coverage Declined for: Myself Spouse Dependents Enrolled in other Insurance Carrier Plans - Carrier Name and ID Number: _____

3. Life Coverage Declined for: Myself Spouse Dependents Spouse covered by employer's group medical coverage Spouse covered by employer's group dental coverage Medicare Covered by Campus or Champva Other (Explain): _____

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 six months.

Please sign here ONLY if you are declining coverage for yourself or dependent(s). _____ Date (Month/Day/Year) _____

E. 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. _____

After completion, sign, remove tape from inside pages, fold closed and press to seal, and submit to your employer.

Conditions of Enrollment (continued from Page 3)

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"), including pharmacies or pharmacy benefit managers to give to Aetna or its agent information concerning the medical history, prescription history, services or treatment provided to anyone listed on this Enrollment form, including those involving mental health, substance abuse and AIDS or AIDS-related complex. 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 is valid for thirty (30) months from the date it is signed. 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. The plan may request additional authorizations as may be required by applicable law.

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 6 months.

Misrepresentation

8. Attention California Residents: For your protection, California law requires notice of the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

I represent that all information supplied in this form is true and complete to the best of my knowledge or belief. I have read and agree to the Conditions of Enrollment and Misrepresentation on this California Small Group Business (2 - 50 Eligible Employees) Employee Enrollment/Change Form. I understand that in the event I fail to sign and return this form to my employer within either the open enrollment period or 31 days after eligibility for enrollment or request for coverage change, or if for any reason Aetna does not receive notice of the above transaction request within a reasonable time following eligibility to enroll in or change coverage, 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 30 hours per week or permanent part time at least 20 hours per week for this employer at the regular place of business.

CA HMO ENROLLEES - NOTICE OF BINDING ARBITRATION: ANY DISPUTE ARISING FROM OR RELATED TO HEALTH PLAN MEMBERSHIP WILL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION, AND NOT BY A LAWSUIT OR RESORT TO COURT PROCESS EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. THE AGREEMENT TO ARBITRATE INCLUDES, BUT IS NOT LIMITED TO, DISPUTES INVOLVING ALLEGED PROFESSIONAL LIABILITY OR MEDICAL MALPRACTICE, THAT IS, WHETHER ANY MEDICAL SERVICES COVERED BY THIS AGREEMENT WERE UNNECESSARY OR WERE UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENCELY OR INCOMPETENTLY RENDERED. THE HEALTH PLAN AGREEMENT ALSO LIMITS CERTAIN REMEDIES AND MAY LIMIT THE AWARD OF PUNITIVE DAMAGES. SEE THE EVIDENCE OF COVERAGE FOR FURTHER INFORMATION.

I understand that I am giving up the constitutional right to have disputes decided in a court of law before a jury, and instead am accepting the use of binding arbitration. This means that members will not be able to try their case in court. I further understand that the agreement contains limitations on certain remedies and that there may be certain limitations to the recovery of punitive damages.

Employee Signature	Spouse Signature	Employee E-mail Address (optional)	Date (Mo/Day/Yr)
X	X		

There are two places on the form where the employee signature can go.

The first signature box (usually located on the first page) should only be signed if the employee is declining coverage. (See Page 1 – circled in red)

The other signature box is usually located on the last page of the form. A signature is required on this page.

If the signature is missing, the enrollment form may be returned, causing a delay in the enrollment process.

Certain states require a completed Health Statement; please refer to your state form.

This concludes our review of some of the commonly misunderstood parts of the Enrollment/Change form. We hope that this will help you in assisting your employees in filling this form out correctly.

Thank you for taking the time to view this presentation.

Presented by: Aetna Consumer Markets