Aetna®

Enrollment/Change Request
Aetna Life Insurance Company

TO COMPLY WITH WASHINGTON LAW, WHEREVER THE TERM "SPOUSE" APPEARS, IT WILL BE CONSTRUED TO INCLUDE DOMESTIC PARTNER.

Employer Group Information: (To Be Completed by Employer)	Employer Name - Full Name of Business or Organization	Control	Suffix	Account	Plan Number
	Employer Address (Street, City, State, ZIP Code) - Primary Location of Business or Organization	Group Number (IMO Only)		Customer Code (Optional)	

A. Type of Activity - Employee Completes Sections A - E. *Please Print Clearly.*

Instructions: Refer to the instructions on the back before completing this form. You, the employee, must complete this application in full or it will be returned to you resulting in a delay in processing. You are solely responsible for its accuracy and completeness.

Enrollment - *Check one.*
- ☐ New Enrollee/Subscriber — Effective Date / / — Date of Hire / /
- ☐ Rehire/Reinstatement — Date of Rehire/Reinstatement / /

Change - *Check all that apply.*
- ☐ Add Spouse/Domestic Partner
- ☐ Add Dependent Child
- ☐ Name Change
- ☐ Other
- ☐ Control/Suffix/Acct/Plan

Date of Event / / — Reason

Remove or Terminate - *Check all that apply.*
- ☐ Remove Spouse/Domestic Partner
- ☐ Remove Dependent Child
- ☐ Employee Withdrawal/ Termination
- ☐ Cancel Coverage

Effective Date / / — Reason

Continuation of Coverage, i.e., COBRA, State - *Not all options are available. Contact Employer for available options.*

Coverage For: ☐ Employee ☐ Dependents

Length of Continuation (months): ☐ 18 ☐ 36 ☐ Other ______

☐ 29 - Attach disability determination from the Social Security Admin.

Date of Loss of Coverage / /

Date of Qualifying Event / /

Continuation of Coverage Expiration Date / /

B. Employee Information

Social Security Number	Last Name, First Name, M.I.			Home Telephone ( )	Work Telephone ( )
Employee Status ☐ Active ☐ Retired	Home Address	Apt. No.	City, State	ZIP Code	

~~Beneficiary Designation - Full Beneficiary Name (First, Middle, last) If more than one beneficiary, use Special Remarks (Section D). | Social Security Number of Beneficiary | Relationship to Employee | Earnings ☐ Annually $ ☐ Weekly $ | ☐ Insurance Amount $ ☐ Supplemental Life $ ☐ AD&D Amount $~~

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

Check One:
- ☐ Aetna Choice® POS II
- ☐ Aetna HealthFund®
- ☐ Aetna Open Access® Elect Choice
- ☐ Aetna Open Access® Managed Choice
- ☐ Elect Choice® EPO
- ☐ Managed Choice® POS
- ☐ Open Choice® PPO
- ☐ Traditional Choice®
- ☐ Other ______

While the Federal Patient Protection and Affordable Care Act generally mandates coverage of dependent children up to age 26, your plan may allow coverage beyond age 26. Please refer to your plan documents or contact your benefits administrator.

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. ☐ **Check this box if you are refusing coverage for your dependents.** ** Provide details for "Yes" responses below.*

(A)dd (C)hange (R)emove	Name (First, Middle Initial, Last) (Explain difference in last names in Special Remarks.)	Relation. Code	Sex M F	Birthdate MM DD YYYY	Social Security Number (If dependent has no SSN, write "None")	Prior Insur. Plan	Other Medical Coverage	Other Rx Drug Coverage	Handi-capped	Primary Medical Office ID Number	Current Patient	Race/Ethnicity - *Optional* Code	Other
		Self	☐ ☐	/ /		Yes * ☐	Yes * ☐	Yes * ☐	Yes N/A		Yes ☐		
			☐ ☐	/ /		☐	☐	☐	☐		☐		
			☐ ☐	/ /		☐	☐	☐	☐		☐		
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			☐ ☐	/ /		☐	☐	☐	☐		☐		

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.)

Using the KEY below, please identify the Race/Ethnicity code for each individual.

KEY:
- **01** - White
- **02** - African American or Black
- **03** - Hispanic or Latino
- **04** - Asian
- **05** - Other (Provide race/ethnicity in "Other" column at left)

1. If "Yes" to **Prior Insurance Plan** and/or **Other Medical Coverage** above, provide effective dates, name & policy number of insurance carrier or other source and your **Member Identification Number.**
2. If "Yes" to **Other Rx Drug Coverage** above, provide effective dates, name & policy number of insurance carrier or other source and your **Member Identification Number.**
3. Does any dependent listed above live at a different address than the employee? If "Yes," who and what address? ☐ Yes ☐ No

Special Remarks

E. Employee Signature ☐ *By checking this box you agree to use Aetna's member self-service website for all future printed materials and understand you may choose to receive paper documents in the future. To view this material please visit Aetna Navigator®.*

I certify that all information supplied in this form is true and complete to the best of my knowledge and/or belief. I have read and agree to the Conditions of Enrollment on the reverse side of this Enrollment/Change Request form.

Misrepresentation: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Employee Signature *(Required)* X ______ **Date** / / **Employee E-mail Address** ______ **Primary Language Spoken** ______