NOTE: Before submitting this completed form to your employer, you may wish to protect the confidentiality of your health information by taping or stapling the form so that health information is not visible.

aetna®

Pennsylvania Employee Enrollment/Change Form
(2 - 50 Eligible Employees)

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 A and B.**

Group Number
Member Aetna ID Number (if available)

Company Name

Effective Date / **Date of Hire**				
	☐ New Hire ☐ Rehire/Reinstatement ☐ New Group Enrollment ☐ Late Enrollment ☐ Waiver ☐ Open Enrollment ☐ Other _____	☐ Change of Coverage ☐ Add Spouse/Domestic Partner ☐ Add Dependent Child ☐ Name Change ☐ Other _____	☐ Employee Termination ☐ Remove Spouse/ Domestic Partner ☐ Remove Dependent Child ☐ Cancel Coverage	☐ COBRA ☐ State Continuation for: ☐ Employee ☐ Dependent Length of Continuation: ☐ 9 ☐ 18 ☐ 36 ☐ Other ____ Original Qualifying Event Date _____ Qualifying Event _____

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

Last Name, First Name, M.I.		Job Title	
Home Address	Apt. No.	City, State	ZIP Code
Work Address		City, State	ZIP Code
Home Telephone ( ) -	Work Telephone ( ) -	Primary Language Spoken (Optional)	No. of Hours Worked Per Week
Salary **$** ☐ Hourly ☐ Weekly ☐ Monthly		Check One ☐ Full-Time ☐ Part-Time ☐ 1099 ☐ Retired ☐ Seasonal ☐ Temporary ☐ Union ☐ COBRA	

B. 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.*

I understand I am eligible to apply for this coverage through my employer; however, I am waiving coverage as noted below.

☐ **Medical declined for:**
☐ Myself ☐ Spouse/Domestic Partner ☐ Child(ren)

☐ **Dental declined for:**
☐ Myself ☐ Spouse/Domestic Partner ☐ Child(ren)

☐ **Life declined for:**
☐ Myself ☐ Spouse/Domestic Partner ☐ Child(ren)

☐ **Disability declined for:**
☐ Myself

Reason for Declining Coverage

☐ Spouse/Domestic Partner group coverage
☐ Parental group coverage
☐ COBRA coverage
☐ Medicare
☐ Medicaid
☐ Retiree coverage
☐ Another group plan provided by my employer
☐ Insurance through another job
☐ Individual coverage - On or Off Exchange
☐ TRICARE Military coverage
☐ Do not want
☐ Other _____

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 I and/or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage.

Please sign here ONLY if you are declining coverage for yourself or your dependent(s).	***Date (Month/Day/Year)***
X Employee Signature	

C. Coverage Selection – ***Please print clearly, using black ink. (Top boxes for Employer/Aetna-Use Only.)***

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

1. Medical ☐ Yes ☐ No *To enroll, check one and enter the plan option elected following the plan type below.*

- ☐ **PA HMO** – Plan Option: _____
- ☐ **PA HMO HSA Compatible** – Plan Option: _____
- ☐ **PA Health Network Only** – Plan Option: _____
- ☐ **PA QPOS** – Plan Option: _____
- ☐ **PA Health Network Option** – Plan Option: _____
- ☐ **PA Health Network Option HSA Compatible** – Plan Option: _____
- ☐ **PA PPO** – Plan Option: _____
- ☐ **PA PPO HSA Compatible** – Plan Option: _____
- ☐ **PA Indemnity** – Plan Option: _____
- ☐ **Other Plan** – Plan Option: _____

Control/Group No.	Suffix	Account	Plan No.

2. Dental ☐ Yes ☐ No *To enroll, enter the plan number and name elected below.*

Contributory Plans: Plan Number _____ Plan Name: _____ If FOC, choose: ☐ DMO® *or* ☐ PPO

Voluntary Plans: Plan Number _____ Plan Name: _____ If FOC, choose: ☐ DMO® *or* ☐ PPO

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

Control/Group No.	Suffix	Account	Plan No.

3. Life and Disability ☐ Yes ☐ No *Check applicable boxes.*

☐ Basic Life/AD&D Ultra® ☐ Optional Dependent Life ☐ Life & Disability Packaged Plan

Full Beneficiary Name (First, Middle, Last)	Beneficiary Social Security Number	Birthdate (MM/DD/YYYY) / /
Beneficiary Address (Number, Street, **Apt. No.**, City, State, ZIP Code)	Telephone Number ( ) -	Relationship to Employee

D. Individuals Covered - ***List individuals for whom you are enrolling or adding/changing/removing coverage. Insert additional sheets if necessary and staple to the back of this application.*** **NOTE FOR MEDICAL AND DENTAL COVERAGE:** While the Federal Patient Protection and Affordable Care Act mandates coverage of dependent children up to age 26, your plan may allow coverage beyond age 26 for medical plans and some dental plans. Some exceptions apply. Please refer to your plan documents or contact your benefits administrator.

If any person has used tobacco products (cigarettes, pipe, cigars, snuff, or chewing tobacco) an average of four or more times per week within the past six months, ✓ check below. Religious or ceremonial uses of tobacco (for example, by American Indians and Alaska Natives) are exempt. This only applies to enrolling person(s) that meet or exceed the state-defined legal tobacco age.

1 (**A**)dd (**C**)hange ___ (**R**)emove	**Employee Name** (Last, First, M.I.)	Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /
Coverage Election ☐ Medical ☐ Dental ☐ Life/Disability	If choosing HMO, Primary Office ID #	Current Patient **Yes** ☐	If choosing DMO, Primary Office ID #	Current Patient **Yes** ☐
Tobacco Use ☐ Yes ☐ No	Currently participating in Quit Smoking Program ☐ Yes ☐ No		Incapacitated ☐ Yes ☐ No	

2 (**A**)dd (**C**)hange ___ (**R**)emove	**Name** (Last, First, M.I.) ☐ **Spouse** ☐ **Domestic Partner**	Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /
Coverage Election ☐ Medical ☐ Dental ☐ Life	If choosing HMO, Primary Office ID #	Current Patient **Yes** ☐	If choosing DMO, Primary Office ID #	Current Patient **Yes** ☐
Tobacco Use ☐ Yes ☐ No	Currently participating in Quit Smoking Program ☐ Yes ☐ No		Incapacitated ☐ Yes ☐ No	

3 (**A**)dd (**C**)hange ___ (**R**)emove	**Name** (Last, First, M.I.) ☐ **Child** ☐ **Stepchild** ☐ **Other**	Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /
Coverage Election ☐ Medical ☐ Dental ☐ Life	If choosing HMO, Primary Office ID #	Current Patient **Yes** ☐	If choosing DMO, Primary Office ID #	Current Patient **Yes** ☐
Tobacco Use ☐ Yes ☐ No	Currently participating in Quit Smoking Program ☐ Yes ☐ No		Incapacitated ☐ Yes ☐ No	

continued on next page

D. Individuals Covered *(continued)*

4	(**A**)dd (**C**)hange (**R**)emove ___	**Name** (Last, First, M.I.) ☐ **Child** ☐ **Stepchild** ☐ **Other**	Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /
Coverage Election ☐ Medical ☐ Dental ☐ Life		If choosing HMO, Primary Office ID #	Current Patient **Yes** ☐	If choosing DMO, Primary Office ID #	Current Patient **Yes** ☐
Tobacco Use ☐ Yes ☐ No		Currently participating in Quit Smoking Program ☐ Yes ☐ No		Incapacitated ☐ Yes ☐ No	

5	(**A**)dd (**C**)hange (**R**)emove ___	**Name** (Last, First, M.I.) ☐ **Child** ☐ **Stepchild** ☐ **Other**	Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /
Coverage Election ☐ Medical ☐ Dental ☐ Life		If choosing HMO, Primary Office ID #	Current Patient **Yes** ☐	If choosing DMO, Primary Office ID #	Current Patient **Yes** ☐
Tobacco Use ☐ Yes ☐ No		Currently participating in Quit Smoking Program ☐ Yes ☐ No		Incapacitated ☐ Yes ☐ No	

6	(**A**)dd (**C**)hange (**R**)emove ___	**Name** (Last, First, M.I.) ☐ **Child** ☐ **Stepchild** ☐ **Other**	Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /
Coverage Election ☐ Medical ☐ Dental ☐ Life		If choosing HMO, Primary Office ID #	Current Patient **Yes** ☐	If choosing DMO, Primary Office ID #	Current Patient **Yes** ☐
Tobacco Use ☐ Yes ☐ No		Currently participating in Quit Smoking Program ☐ Yes ☐ No		Incapacitated ☐ Yes ☐ No	

E. Dependent Information

List any dependent in Section **D** living at another address.

Name	Address

For Dependent Life Only – Student Status: If age 19 and over and a full-time student, provide the following:

Child Name	School Name	Expected Graduation Date	Number of Credit Hours

F. Coordination of Benefits

Will you have other health insurance at the same time as this coverage? ☐ Yes ☐ No

Name of Person	Carrier Name	Name of Person	Carrier Name

G. Case Management (OPTIONAL – This information will be used to help coordinate your care. It will not impact your premium rate or eligibility for coverage.)

- ☐ AIDS
- ☐ ALS (Amyotrophic lateral sclerosis) - Lou Gehrig's disease
- ☐ Auto Immune Disorders (e.g., scleroderma, Systemic Lupus)
- ☐ Traumatic Brain Injury
- ☐ Cerebral Palsy using wheelchair
- ☐ Chronic Pain
- ☐ Congestive Heart Failure
- ☐ COPD using oxygen
- ☐ Cor Pulmonale
- ☐ Defibrillator /AICD/ Implantable Cardioverter
- ☐ End of Life/Hospice
- ☐ Hypertensive Heart Disease
- ☐ Hypertensive Renal Disease
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Myasthenia Gravis
- ☐ Paralysis
- ☐ Paraplegic
- ☐ Pregnant - high risk or multiple births
- ☐ Quadriplegic

Name of Individual	Condition(s)

Conditions of Enrollment

On behalf of myself and the dependents listed on Pages 2 and 3, 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 HMO plans and Aetna POS plans: Aetna Health Inc. and/or Aetna Health Insurance Company
   - Aetna PPO plans: Aetna Life Insurance Company
   - Life, Accidental Death & Personal Loss, disability, dental 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 enrollment form and the employer application have been accepted and approved by Aetna. Even if this enrollment form is approved, any intentional and material misstatements or omissions that amount to fraud, or which would have affected the carrier's rating, offering or issuing of coverage impacted, 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 and disability 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. For Dependent Life, dependents are eligible from 14 days of age up to their 19th birthday, or up to their 23rd birthday, if a full-time student.
3. I understand and agree that this Enrollment/Change 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 and pharmacy database benefit managers to give Aetna or its agent information concerning the medical history, prescription utilization history, services or treatment provided to anyone listed on this Enrollment/Change 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/domestic partner and competent adult dependents and I have obtained their consent to those terms. This authorization will remain valid for the term of the coverage and 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.

Misrepresentation

7. 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 subjects such person to criminal and civil penalties.

I represent that all information supplied in this form is true and complete to the best of my knowledge and belief. I have read and agree to the Conditions of Enrollment and Misrepresentation on this **Pennsylvania** 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 25 hours per week for this employer at the regular place of business.

Employee Signature (Required to enroll)	***Employee E-mail Address (optional)***	***Date (Month/Day/Year) – Required***
X		