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.

Pennsylvania Employee Enrollment/Change Form (51-100 Eligible Employees)

Group Number
Member Aetna ID Number (if available)

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.**

Company Name			
Effective Date	☐ New Hire	☐ Add Spouse	☐ Employee Termination
	☐ Rehire/Reinstatement*	☐ Add Domestic Partner	☐ Remove Spouse
Date of Hire	☐ New Group Enrollment	☐ Add Dependent Child	☐ Remove Domestic Partner
	☐ Late Enrollment	☐ Change of Coverage	☐ Remove Dependent Child
BWP	☐ Waiver	☐ Name Change	☐ Cancel Coverage
☐ Class 1 ☐ Class 2	☐ Open Enrollment		☐ Other ________
	* Does not apply to Supplemental or Dependent Life Insurance		

☐ **COBRA** ☐ **Continuation for:** ☐ Employee ☐ Dependent Length of Continuation: ☐ 18 ☐ 36 ☐ Other ________
Qualifying Event ________ Original Qualifying Event Date ________ Loss of Coverage Date ________

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

Social Security Number	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. Declination/Waiver of Coverage – *To be completed if coverage is declined or refused by an eligible employee and/or their eligible family members.*

☐ Employee: ☐ Medical ☐ Life ☐ Dental ☐ Vision ☐ Disability	**Reason for declining coverage**
☐ Spouse: ☐ Medical ☐ Life ☐ Dental ☐ Vision	☐ Spouse/Civil Union/Domestic Partner group coverage ☐ Parental group coverage ☐ Medicare ☐ Medicaid ☐ Retiree coverage ☐ Another group plan provided by my employer
☐ Child(ren): ☐ Medical ☐ Life ☐ Dental ☐ Vision	☐ COBRA coverage ☐ Insurance through another job ☐ TRICARE or CHAMPVA ☐ Individual coverage – On Exchange ☐ Individual coverage – Off Exchange ☐ 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). Employee Signature X	*Date (Month/Day/Year)*

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 QPOS** – Plan Option: ____________ Rx Option: ____________
☐ **PA QPOS Savings Plus** – Plan Option: ____________
☐ **PA Health Network Option** – Plan Option: ____________ Rx Option: ____________
☐ **PA Health Network Option HSA Compatible** – Plan Option: ____________
☐ **PA PPO** – Plan Option: ____________ Rx Option: ____________
☐ **PA PPO HSA Compatible** – Plan Option: ____________
☐ **PA AWH PPO** – Plan Option: ____________
☐ **PA AWH 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

Creditable coverage is allowed for new members enrolling in voluntary takeover groups. New hires please see below if applicable:
New Hire selecting a Voluntary Plan **and your Aetna plan is a takeover group**: Were you covered for 12 months under a dental plan within the last 90 days that included both Preventive and Basic coverage? Discount dental and preventive only plans do not apply. ☐ Yes ☐ No

Control/Group No.	Suffix	Account	Plan No.

3. Life and Disability

Life Options – Check applicable boxes.

☐ **Employee**	☐ Basic Life/AD&PL Ultra	☐ Supplemental Life	☐ Supplemental AD&PL
☐ **Spouse**	☐ Dependent Life	☐ Dependent Supplemental Life	☐ Dependent Supplemental AD&PL
☐ **Child**	☐ Dependent Life	☐ Dependent Supplemental Life	☐ Dependent Supplemental AD&PL

DESIGNATION OF BENEFICIARY – Carefully review Additional Conditions and Instructions for Designation of Beneficiary on Page 6.
Life Products require the employee to designate a beneficiary for benefits. A beneficiary is the person or entity who will receive the benefit payment. A primary beneficiary will be the first to receive the benefit. A contingent beneficiary will only receive the benefit payment if the primary beneficiary dies or is no longer available. The employee is automatically the primary beneficiary for dependent life and AD&PL benefits.

Beneficiary For:	**Full Name(s) or Entity (Trust or Estate)**	**Date of Birth**	**Social Security Number / Tax ID Number**	**Address** (Number, Street, Apt. No., City, State, ZIP Code)	**Phone**	**Relationship to Employee**	**% of Benefit** (must equal 100%)
Basic Life Primary							
Basic Life Contingent							
Supplemental Life Primary							
Supplemental Life Contingent							

SPOUSAL CONSENT FOR COMMUNITY PROPERTY STATES – See Additional Conditions and Instructions for Designation of Beneficiary Section on Page 6.

Please note that an Employee is under no obligation to complete the Spousal Consent section on this form.

I am aware that my spouse, the Employee named above, has designated someone other than me to be the beneficiary of group Life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.

Spouse Signature ____________________ **Date** ____________

Disability Options - Check applicable boxes. **Employee only**

Short Term Disability ☐ Yes ☐ No
Long Term Disability ☐ Yes ☐ No

Control/Group No.	Suffix	Account	Plan No.

4. Vision

Aetna Vision Preferred ☐ Yes ☐ No *Check applicable box.*

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 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. Some exceptions apply. Please refer to your plan documents or contact your benefits administrator.

1	**(A)**dd **(C)**hange **(R)**emove ___	**Employee Name** (Last, First, M.I.)				Sex (M/F)
Birthdate (MM/DD/YYYY) / /		Coverage Election ☐ Medical ☐ Dental ☐ Vision ☐ Life ☐ Disability	PCP Provider ID Number	Current Patient **Yes** ☐	Dental Office ID Number	Current Patient **Yes** ☐

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 ☐ Vision ☐ Life	PCP Provider ID Number	Current Patient **Yes** ☐	Dental Office ID Number	Current Patient **Yes** ☐

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 ☐ Vision ☐ Life	PCP Provider ID Number	Current Patient **Yes** ☐	Dental Office ID Number	Current Patient **Yes** ☐
Incapacitated ☐ Yes ☐ No						

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 ☐ Vision ☐ Life	PCP Provider ID Number	Current Patient **Yes** ☐	Dental Office ID Number	Current Patient **Yes** ☐
Incapacitated ☐ Yes ☐ No						

E. **Dependent Information**

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

Name	Address

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. **Medicare Information**

Name of Person	Medicare Part A	Medicare Part B	Medicare Part D	Over Age 65	Disability	End-Stage Renal Disease Effective Date
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

H. **Health Questionnaire must be completed for:**

- Employer group with no group medical coverage;
- A newly formed business with no group medical coverage;

NOTE: Individuals requesting life coverage above the Guaranteed Issue amount or a Life/Disability Late Enrollee (enrolling more than 31 days after eligible) must complete an Evidence of Insurability Form and send to the address located on the form.

Health History for Individuals and your Dependents. ***The following information is confidential and will not be seen by or given to your employer.***

- ALL of the questions must be answered by you and your dependents or the application will be returned.
- Incomplete enrollment forms may delay the effective date of your coverage.

List all individuals enrolling for coverage. Name	Sex	Age	Height	Weight	Cigarette Smoker	Currently Taking Prescription Medication(s)
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No

I. Answer all questions.

1. Within the last **five** years has anyone applying for coverage consulted, received treatment, by a doctor, psychiatrist, psychologist, or other practitioner or been diagnosed with any of the following conditions or disorders? (Check all that apply.) ☐ Yes ☐ No

a. ☐ AIDS/ARC/HIV
b. ☐ Diabetes
c. ☐ Infertility
d. ☐ Endocrine Metabolic
e. ☐ Pancreas
f. ☐ Liver/Hepatitis
g. ☐ Immune System
h. ☐ Blood Disorder
i. ☐ Hemophilia
j. ☐ Epilepsy/Seizure
k. ☐ Heart Disorder/Disease
l. ☐ Paralysis/Paresis
m. ☐ Tumor/Cyst/Growth
n. ☐ Systemic or Discoid Lupus
o. ☐ Lung or Respiratory
p. ☐ Alcohol or Drug Use
q. ☐ Kidney/Bladder/Urinary
r. ☐ Circulatory/Vascular
s. ☐ Digestive/Stomach/Intestinal
t. ☐ Central Nervous System
u. ☐ Connective Tissue Disorder
v. ☐ Pituitary/Adrenal/ Growth Disorder
w. ☐ Birth Defects/Congenital Abnormalities
x. ☐ Arthritis/Bone/Joint/Muscle/Prosthetic Device
y. ☐ Mental/Nervous/Emotional/Eating Disorder
z. ☐ Stroke/Brain/Neurological
aa. ☐ Transplant: ☐ Recommended ☐ Pending ☐ Complete
bb. ☐ Advised to have ☐ tests, ☐ surgery, ☐ hospitalization or is ☐ treatment needed, or ☐ course of treatment not yet determined
cc. ☐ Cancer: Type:____________________ Stage ______ ☐ Surgery ☐ Chemo ☐ Radiation
dd. ☐ Using: ☐ Crutches ☐ Walker ☐ Wheelchair
ee. ☐ Other ____

2. Is any female currently pregnant? If so, provide due date ______________ Check applicable boxes: ☐ C section planned ☐ Multiple Births Expected (# _____) ☐ Complications: ☐ Past or ☐ Present — ☐ Yes ☐ No
3. Has anyone applying for coverage incurred medical expenses in excess of $5,000 in the past 24 months? ☐ Yes ☐ No
4. Has anyone applying for coverage been prescribed medications in the past 12 months? ☐ Yes ☐ No
5. Does anyone applying for coverage have a known condition that requires on-going treatment? ☐ Yes ☐ No

J. Provide details below to any boxes checked in Section I. *(If additional space is needed, attach a separate sheet and be sure to sign and date the sheet.)*

Ques. No.	Name of Individual	Condition/Diagnosis/ Treatment	Date of Onset	Date Treatment Ended	Names of Prescription Medication	Dosage	Still Taking Medication
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

continued on next page

J. Provide details below to any boxes checked in Section I. *(continued)*							
Ques. No.	Name of Individual	Condition/Diagnosis/ Treatment	Date of Onset	Date Treatment Ended	Names of Prescription Medication	Dosage	Still Taking Medication
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

Conditions of Enrollment

On behalf of myself and the dependents listed, 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 Health Network plans and Aetna POS plans: Aetna Health Inc. and/or Aetna Health Insurance Company
   - Aetna PPO plans: Aetna Life Insurance Company
   - Life, Disability, Accidental Death and Personal Loss, Dental and all other coverages: Aetna Life Insurance Company
   - Aetna Vision^{SM} Preferred plans: Aetna Life Insurance Company; certain claims adjudication and other administrative services are provided by First American Administrators, Inc. (an affiliate of EyeMed Vision Care, LLC) and/or its affiliates.
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 coverage: I understand that the effective date of insurance for myself or for any of my dependents is subject to my being active 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, dependent children are eligible from birth up to their 26th birthday.
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. This authorization is voluntary. However, I understand that if I refuse to sign this authorization form, my ability to enroll in the medical plans described above may be affected. I have the right to revoke this authorization in writing to Aetna at any time except to the extent that my information has already been used or disclosed in reliance on this authorization. However, because this information is essential to the administration of the plans, I understand that my revocation of this authorization may result in cancellation of my enrollment in the medical plans described above.
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 eligibility 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. I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments as required for coverage.

If you wish to receive documents electronically, please refer to Aetna Navigator® at http://www.aetna.com/individuals-families/aetna-navigator.html.

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

Additional Conditions and Instructions for Designation of Beneficiary

Conditions for Designation of Beneficiary

- **Please note:** The Group Contract grants the member the authority to designate a beneficiary. A beneficiary designated by someone other than the member (i.e., attorney-in-fact, Power of Attorney, guardian, custodian, etc.) may be barred under the Group Contract, by the Power of Attorney executed by the member and/or by state law. The member should execute the beneficiary designation section of this form whenever possible to ensure the designation is deemed valid.
- Unless otherwise expressly provided in the Designation of Beneficiary section of this form, if any named beneficiary predeceases me, the life proceeds shall be payable equally to the remaining named beneficiary or beneficiaries. If no named beneficiary survives me, any sum becoming payable under said Group Policy(ies) by reason of my death shall be payable as prescribed in said Group Policy(ies).
- If this Designation of Beneficiary provides for payment to a trustee under a trust agreement, Aetna Life Insurance Company shall not be obliged to inquire into the terms of the trust agreement and shall not be chargeable with knowledge of the terms thereof. Payment to and receipt by the trustee shall fully discharge all liability of said Insurance Company to the extent of such payment.
- If you live in one of the following community property states – Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin – your spouse may have a legal claim for a portion of the life insurance benefit under state law. If you name someone other than your spouse as beneficiary, payment of the death benefit may be delayed until your spouse's claim is resolved.

Instructions for Designation of Beneficiary

If these instructions do not answer all your questions, please contact your plan sponsor for assistance.
Please use only black ink to complete this form.

- If you make a mistake in completing this form, line out the erroneous information, add the correct information and initial the correction. **The printed material on this form should not be deleted or altered in any way.**
- **In all cases**, the relationship of the beneficiary, the beneficiary's Social Security Number, address and phone number should be included with the beneficiary designations.
- **Dollars and cents should not be specified**.
- If a minor child is named beneficiary, the child will not receive the benefits until age of majority.
- If a trustee is named beneficiary, show the exact name of the trust, date of the trust agreement, and the name and address of the trustee. **For example**, The John J. Smith Revocable Life Insurance Trust, dated January 1, 1994. John Smith, Trustee, 123 Apple Lane, Hartford, CT 06006.