



New York Small Group Business (2 - 50 Eligible Employees) Employee Enrollment/Change Form

Member Aetna ID Number (if available)

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	<input type="checkbox"/> New Hire	<input type="checkbox"/> Late Enrollment	<input type="checkbox"/> Change of Coverage	<input type="checkbox"/> Employee Termination	COBRA/State Continuation for: <input type="checkbox"/> Employee <input type="checkbox"/> Dependent Length of Continuation: <input type="checkbox"/> 18 <input type="checkbox"/> 36 <input type="checkbox"/> Other _____ Original Qualifying Event Date _____ Reason _____
Date of Hire	<input type="checkbox"/> Rehire/Reinstatement	<input type="checkbox"/> Other _____	<input type="checkbox"/> Add Spouse/Dependent Child	<input type="checkbox"/> Remove Spouse/Dependent Child	
	<input type="checkbox"/> New Group Enrollment		<input type="checkbox"/> Name Change	<input type="checkbox"/> Other _____	

A. Coverage Selection - Please print clearly, using black ink. (Shaded sections for Employer/Aetna Use Only)

Control/Group No.	Suffix	Account	Plan No.	Class Code	Control/Group No.	Suffix	Account	Plan No.	Control/Group No.	Suffix	Account	Plan No.
1. Medical - Check one. Managed Choice Open Access: <input type="checkbox"/> 21a-07 <input type="checkbox"/> 21b-07 <input type="checkbox"/> 21c-07 <input type="checkbox"/> 22a-07 <input type="checkbox"/> 22b-07 <input type="checkbox"/> 22c-07 <input type="checkbox"/> 24a-07 <input type="checkbox"/> 24b-07 <input type="checkbox"/> 24c-07 <input type="checkbox"/> 26a-07 <input type="checkbox"/> 26b-07 <input type="checkbox"/> 26c-07 <input type="checkbox"/> 27-07 <input type="checkbox"/> 29a-07 <input type="checkbox"/> 29b-07 <input type="checkbox"/> 29c-07 <input type="checkbox"/> 33a-07 <input type="checkbox"/> 33b-07 <input type="checkbox"/> 33c-07 Managed Choice Open Access (HSA Compatible): <input type="checkbox"/> 30-07 <input type="checkbox"/> 31-07 <input type="checkbox"/> 34-07 EPO Open Access: <input type="checkbox"/> 1a-07 <input type="checkbox"/> 1b-07 <input type="checkbox"/> 1c-07 <input type="checkbox"/> 2a-07 <input type="checkbox"/> 2b-07 <input type="checkbox"/> 2c-07 <input type="checkbox"/> 3a-07 <input type="checkbox"/> 3b-07 <input type="checkbox"/> 3c-07 <input type="checkbox"/> 4a-07 <input type="checkbox"/> 4b-07 <input type="checkbox"/> 4c-07 Indemnity: <input type="checkbox"/> 20-07					2. Dental - Check one. Standard Plans <input type="checkbox"/> Option 2: DMO <input type="checkbox"/> Option 4: PPO Max <input type="checkbox"/> Option 3: <input type="checkbox"/> Option 5: Active PPO Freedom-of-Choice: <input type="checkbox"/> Option 6: Passive PPO DMO ____ or PPO ____ <input type="checkbox"/> Option 7: Consumer Directed <input type="checkbox"/> Out-of-State PPO Plan Voluntary Plans <input type="checkbox"/> Option 2: DMO <input type="checkbox"/> Option 3: Freedom-of-Choice: DMO ____ or PPO ____ <input type="checkbox"/> Option 4: PPO Max <input type="checkbox"/> Out-of-State PPO Plan Before today, were you covered under this employer's dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No					3. Life <input type="checkbox"/> Basic Life / AD&D Ultra™ <input type="checkbox"/> Optional Dependent Life <input type="checkbox"/> Life & Disability Packaged Plan Beneficiary Designation - Full Name (First, Middle, Last) _____ Beneficiary Social Security No. _____ Relationship to Employee _____		

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

Social Security Number	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) \$ _____	<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	No. of Hours Worked Per Week	Check One <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> 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. Height and weight information needed for Life Insurance applicants only.

Name (Last, First, M.I.)	Sex	Social Security No.	Birthdate	Height (ft., in.)	Weight (lbs.)	Incapacitated	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)	Dental Office ID Number (If applicable)
Employee 1.	M/F		MM / DD / YYYY			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
Spouse 2.						Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
Child 3.						Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
Child 4.						Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		

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: <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents	Reason for Declining Coverage (If applicable, please attach front/back of your health coverage ID card.): <input type="checkbox"/> Covered by spouse's group coverage - Carrier Name and ID _____ <input type="checkbox"/> Enrolled in other Insurance Plans - Insurance Company Name and ID _____ <input type="checkbox"/> Medicare <input type="checkbox"/> Covered by TRICARE or CHAMPVA <input type="checkbox"/> Other (Explain): _____ <input type="checkbox"/> Spouse covered by employer's group medical coverage <input type="checkbox"/> Spouse covered by employer's group dental coverage
2. Dental Coverage Declined for: <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents	

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 or dependent(s).** _____ **Date (Month / Day / Year)** _____

Employee Signature

Conditions of Enrollment (continued)

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 12 months.

Misrepresentation

- 8. 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I represent that all information supplied in this form is true and complete. I have read and agree to the Conditions of Enrollment and Misrepresentation on this New York Small Group Business (2 - 50 Eligible Employees) 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 20 hours per week for this employer at the regular place of business.

<i>Employee Signature</i>	<i>Employee E-mail Address (optional)</i>	<i>Date (Mo./Day/ Yr.)</i>
X		
<i>Employer Signature</i>		<i>Date (Mo./Day/ Yr.)</i>
X		