Pennsylvania 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 A and B.**

Effective Date

Date of Hire

☐ New Hire ☐ Rehire/Reinstatement ☐ New Group Enrollment ☐ Late Enrollment ☐ Open Enrollment ☐ Waiver ☐ Other _____

☐ Change of Coverage ☐ Add Spouse/Dependent Child ☐ Name Change ☐ Other _____

☐ Employee Termination ☐ Remove Spouse/ Dependent Child ☐ Cancel Coverage

COBRA for: ☐ Employee ☐ Dependent
Length of Continuation: ☐ 18 ☐ 36 ☐ Other ____
Original Qualifying Event Date _____
Reason _____

A. 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	No. of Hours Worked Per Week	Check One	Marital Status	No. of Dependents Including Spouse
$ ☐ Hourly ☐ Weekly ☐ Monthly		☐ Part-time ☐ Full-time	☐ Single ☐ Married	

B. 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

2. Dental Coverage Declined for:
☐ Myself ☐ Spouse ☐ Dependents

Reason for Declining Coverage *(If applicable, please attach front/back of your health coverage ID card.)*:
☐ Covered by spouse's group coverage - Carrier Name and ID _____
☐ Enrolled in other Insurance Carrier Plans - Carrier Name and ID _____
☐ Spouse covered by employer's group medical coverage ☐ Spouse covered by employer's group dental coverage
☐ Medicare ☐ Covered by TRICARE 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 other than an HMO 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)***

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

Control/Group No.	Suffix	Account	Plan No.

Control/Group No.	Suffix	Account	Plan No.

1. Medical - Check one.
PA POS: ☐ Plan 1.2 ☐ Plan 2.2 ☐ Plan 3.2 ☐ Plan 4.2 ☐ Plan 5.2 ☐ Plan 6.2
PA POS No Referral: ☐ Plan 1.2 ☐ Plan 2.2 ☐ Plan 3.2 ☐ Plan 4.2
PA POS HSA Compatible No Referral: ☐ Plan 1.2 ☐ Plan 2.2 ☐ Plan 3.2 ☐ Plan 4.2
PA POS Cost-Sharing: ☐ Plan 1.2
PA POS Cost-Sharing No Referral: ☐ Plan 2.2
PA PPO: ☐ Plan 1.1 ☐ Plan 2.1 ☐ Plan 3.1
PA PPO HSA Compatible: ☐ Plan 1.1 ☐ Plan 2.1 ☐ Plan 3.1
☐ PA PPO Basic Hospital Plan 1.1
☐ PA PPO HealthFund Plan 1.1
☐ Other Plan _____

2. Dental - Check one.
Contributory Options:
☐ Option 2 DMO
☐ Option 3 Freedom-of-Choice: ☐ DMO or ☐ PPO
☐ Option 4 PPO Max
☐ Option 5 Active PPO - High Option
☐ Option 6 Passive PPO 1500
☐ Option 7 Consumer Directed Dental Fund
☐ Out-of-State/Situs

Voluntary Options:
☐ Option V2 DMO
☐ Option V3 Freedom-of-Choice: ☐ DMO or ☐ PPO
☐ Option V4 PPO Max
☐ Option V7 Consumer Directed
☐ Out-of-State/Situs

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

3. Life and Disability
☐ Basic Life/AD&D Ultra™
☐ Optional Dependent Life
☐ Life & Disability Packaged Plan

Beneficiary Designation - **Full Name** (First, Middle, Last)

Beneficiary Social Security No.	Relationship to Employee

D. Individuals Covered - *List individuals for whom you are enrolling or adding/changing/removing coverage.* *Insert additional sheets if necessary.*

Name (Last, First, M.I.)	Sex M/F	Social Security No.	Birthdate MM / DD / YYYY	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	Aetna Primary Office ID Number (If applicable)	Current Patient	Dental Office ID Number (If applicable)	Current Patient
Employee 1.			/ /			Yes N/A	☐ Medical ☐ Dental ☐ Life/Dis	Yes ☐	Yes ☐	Yes ☐	Yes N/A	Yes ☐		Yes ☐		Yes ☐
Spouse 2.			/ /			N/A	☐ Medical ☐ Dental ☐ Life	☐	☐	☐	N/A	☐		☐		☐
Child 3.			/ /			☐	☐ Medical ☐ Dental ☐ Life	☐	☐	☐	☐	☐		☐		☐
Child 4.			/ /			☐	☐ Medical ☐ Dental ☐ Life	☐	☐	☐	☐	☐		☐		☐
Child 5.			/ /			☐	☐ Medical ☐ Dental ☐ Life	☐	☐	☐	☐	☐		☐		☐

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 pages 2 and 3 are not visible.

E. 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.)

Employee 1.	☐ White - 01 ☐ African American or Black - 02 ☐ Hispanic or Latino - 03 ☐ Asian - 04 ☐ Other - 05 _____	Child 3.	☐ White - 01 ☐ African American or Black - 02 ☐ Hispanic or Latino - 03 ☐ Asian - 04 ☐ Other - 05 _____
Spouse 2.	☐ White - 01 ☐ African American or Black - 02 ☐ Hispanic or Latino - 03 ☐ Asian - 04 ☐ Other - 05 _____	Child 4.	☐ White - 01 ☐ African American or Black - 02 ☐ Hispanic or Latino - 03 ☐ Asian - 04 ☐ Other - 05 _____

F. Dependent Information

Does any dependent listed in Section D live at another address? ☐ Yes ☐ No If Yes, who and what address?	If any dependent's last name differs from yours, explain the circumstances.

G. Other Insurance

Does anyone enrolling on this enrollment form have prior coverage? ☐ Yes ☐ No

If you are age 65 or older, are you eligible and enrolled for Medicare? ☐ Yes ☐ No
If Yes, provide the effective date: ____/____/_____ (month/day/year) and check the applicable boxes: ☐ Part A ☐ Part B

Proof of coverage must accompany this application for pre-existing condition credit and if an employee is waiving coverage. Acceptable forms of proof are:

1. Certificate of Creditable Coverage from prior carrier, or
2. Copy of ID card or most recent payroll stub showing medical coverage deduction, or
3. Copy of most recent medical premium bill from prior carrier.

Failure to provide Proof of Prior Coverage may subject you or a family member to the full pre-existing conditions limitation with no credit for prior coverage.
You may request a Certificate of Creditable Coverage from your prior carrier.

Name of Covered Individual	Carrier Name	Group Number	Start Date	Termination Date	Health
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

H. Mandatory Health Questionnaire for Groups Enrolling 2 - 19 Employees.

Any employee requesting Basic Life Benefits greater than the Guaranteed Issue Level must also complete the Health Questionnaire below.

Health History for Individuals and Their 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 enrollment form will be returned.
- Incomplete enrollment forms may delay the effective date of your coverage.

In the past five (5) years, has any person listed on the enrollment form seen a health care provider(s), had treatment recommended, received treatment, including prescription medications or been hospitalized for any of the following conditions listed below?

		Yes	No
1.	Heart attack, heart murmur, stroke, chest pain, high blood pressure, anemia, varicose veins or other disorders of the heart, blood, blood vessels or high cholesterol?	☐	☐
2.	Ulcer, colitis, gallstones or any other disorder of the stomach, intestines, rectum, pancreas, liver or Hepatitis B/C?	☐	☐
3.	Cancer, cyst or tumor?	☐	☐
4.	Disorders of the kidneys, adrenal glands, thyroid glands, urinary systems, male or female organs, infertility, menstrual dysfunction or sexually transmitted disease (except AIDS/ARC)?	☐	☐
5.	Asthma, emphysema, tuberculosis or any other disorders of the lungs or respiratory system?	☐	☐
6.	Migraines, fainting spells, epilepsy, mental or nervous conditions, depression, paralysis or any disorder of the brain or nervous system? If epileptic, date of last seizure: ____/____/_____ (month/day/year)	☐	☐
7.	Lupus, arthritis, back trouble or any other disorder of the joints, muscles or bones, including prosthetic device or implants?	☐	☐
8.	Any physical deformity, defect or congenital problem?	☐	☐
9.	Has any person to be covered had or has been told they have an immune disorder, AIDS, or AIDS-Related Complex?	☐	☐
10.	Has any person been treated for alcoholism, other drug or substance abuse, including use of any illegal or controlled drugs, or been advised to seek treatment for the same?	☐	☐
11.	Has any person been diagnosed with diabetes? If Yes, list date of diagnosis: ____/____/_____ (month/day/year) Insulin dependent? _____ Non-insulin dependent? _____	☐	☐
12.	a. Is any female to be covered currently pregnant? If Yes, list due date: ____/____/_____ (month/day/year)	☐	☐
	b. Have there been any complications thus far?	☐	☐
	c. Are multiple births expected?	☐	☐
13.	If you are a male listed on this enrollment form, are you expecting a child with anyone, even if the mother is not listed on this enrollment form?	☐	☐
14.	Has any applicant taken any prescribed medications in the past 12 months? **If Yes, list on next page.**	☐	☐
15.	Has any applicant had an abnormal physical exam or been advised to undergo further testing, surgery or treatment?	☐	☐
16.	Has any applicant been a patient in a hospital, clinic, surgical center, sanatorium or medical facility as an outpatient or inpatient (excluding childbirth)?	☐	☐
17.	Does anyone named on this application use tobacco products, including cigarette, pipe, cigar, or chewing tobacco? If Yes, check applicable boxes: ☐ Employee or ☐ Spouse	☐	☐
18.	Has any applicant had any medical condition or symptom not listed on this enrollment form?	☐	☐

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS ABOVE (EXCEPT QUESTION 9), YOU MUST COMPLETE SECTION J ON THE FOLLOWING PAGE.

If you are providing additional sheets, check here ☐ and insert the sheets before sealing this Enrollment form.

I. Mandatory Health Questionnaire for Northeastern PA Groups* Enrolling 20 - 50 Employees - Employer Groups Located in Other Areas Do Not Need to Complete This Section. (*Northeastern PA Groups are those located in Bradford, Clinton, Columbia, Lackawanna, Luzerne, Lycoming, Northumberland, Pike, Snyder, Sullivan, Susquehanna, Wayne and Wyoming Counties.)

Health History for Individuals and Their 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 enrollment form will be returned.
- Incomplete enrollment forms may delay the effective date of your coverage.

In the past five (5) years, have you, your spouse/domestic partner or any of your dependents:

	Yes	No
1. Had, consulted for, had treatment rendered, been advised to have treatment or been hospitalized for any of the following: Cardiovascular disease or heart attack, stroke; disorder of the kidneys, stomach, intestines or liver; musculoskeletal conditions; mental or nervous condition; central nervous system disorder; diabetes; any disorder of the lungs or respiratory system; cancer or immune deficiency disorder (except HIV), AIDS, or AIDS-related complex?	☐	☐
2. Have you or any dependents to be covered visited a health care professional for any illness and/or medical condition resulting in medical expenses more than $5,000 in the past 24 months?	☐	☐
3. Have you or any dependent to be covered been advised in the last 12 months that hospitalization, surgery or treatment is needed or pending?	☐	☐
4. a. Is any female to be covered currently pregnant?	☐	☐
b. If you are a male listed on this enrollment form, are you expecting a child with anyone, even if the mother is not listed on this enrollment form?	☐	☐
5. Does anyone listed on this enrollment form use tobacco products, including cigarette, pipe, cigar, or chewing tobacco?	☐	☐

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS ABOVE, YOU MUST COMPLETE SECTION J BELOW.

J. Health Questionnaire - Details for "Yes" Responses in Sections H & I.

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS IN SECTIONS H (EXCEPT QUESTION 9) & I, YOU MUST COMPLETE THE FOLLOWING.

Please provide us with FULL DETAILS for each "Yes" answer to any condition(s) checked in Sections H & I. **In addition**, please give details below of last doctor visit and/or physical examination for **ALL** family members listed regardless of the date or reason. *(Insert additional sheets if necessary.)*

Ques. #: [ ] Name of Person: ____________ **Name of Illness/Condition:** ____________

Date of Onset: Month _____ Year _____ Date Treatment Ended: Month _____ Year _____ Still under Treatment: Yes ☐ No ☐

Medication: ____________ Date Prescribed: Month _____ Year _____ Dosage: ____________

Treatment Given: ____________

Ques. #: [ ] Name of Person: ____________ **Name of Illness/Condition:** ____________

Date of Onset: Month _____ Year _____ Date Treatment Ended: Month _____ Year _____ Still under Treatment: Yes ☐ No ☐

Medication: ____________ Date Prescribed: Month _____ Year _____ Dosage: ____________

Treatment Given: ____________

Ques. #: [ ] Name of Person: ____________ **Name of Illness/Condition:** ____________

Date of Onset: Month _____ Year _____ Date Treatment Ended: Month _____ Year _____ Still under Treatment: Yes ☐ No ☐

Medication: ____________ Date Prescribed: Month _____ Year _____ Dosage: ____________

Treatment Given: ____________

Ques. #: [ ] Name of Person: ____________ **Name of Illness/Condition:** ____________

Date of Onset: Month _____ Year _____ Date Treatment Ended: Month _____ Year _____ Still under Treatment: Yes ☐ No ☐

Medication: ____________ Date Prescribed: Month _____ Year _____ Dosage: ____________

Treatment Given: ____________

Ques. #: [ ] Name of Person: ____________ **Name of Illness/Condition:** ____________

Date of Onset: Month _____ Year _____ Date Treatment Ended: Month _____ Year _____ Still under Treatment: Yes ☐ No ☐

Medication: ____________ Date Prescribed: Month _____ Year _____ Dosage: ____________

Treatment Given: ____________

If you are providing additional sheets, check here ☐ and insert the sheets before sealing this Enrollment form.

Conditions of Enrollment

On behalf of myself and the dependents listed on the reverse side, 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 Corporate Health Insurance Company
   - Aetna PPO plans: Aetna Life Insurance Company
   - Life, Accidental Death & Dismemberment, 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 employer applications 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. Failure to disclose all health information encompassed by the questionnaire will be deemed to be material omissions for 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.
3. I understand and agree that this Enrollment/Change Request 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 Request 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 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 for 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 providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.
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 enrollment form 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 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 25 hours per week for this employer at the regular place of business.

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

Employer Signature	*Date (Mo./Day/Yr.)*
X	