Coverage is provided by the following entities: Aetna Health Inc., Aetna Health Insurance Company, and Aetna Life Insurance Company for POS plans and Aetna Life Insurance Company for all other coverage.

Small Group Employee Change of Coverage Application – NV

(For Existing Enrollments Only)

Instructions:

Before requesting a different plan, please read the Aetna brochure describing the plan you are thinking of choosing.

Be sure you are acquainted with the benefits, co-payments, annual deductibles and the limitations and exclusions of the plan you choose.

The plan you choose must be part of your employer's Small Group benefit coverage.

1. **You, the employee, must complete this application.** You are solely responsible for its accuracy and completeness.
2. All questions must be answered in full and all signatures and dates must be included where noted; otherwise, the application may be returned to you, resulting in a delay in processing and possibly a delay in the effective date of coverage.
3. **Type or print clearly using blue or black ink.**

1. Choice of Coverage – *Please change my coverage to:*

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

Control/Group No.	Suffix	Account	Plan No.

A. Medical - Check one.

- ☐ NV PPO 500 80%
- ☐ NV PPO 750 80%
- ☐ NV PPO 1000 80%
- ☐ NV PPO 1500 80%
- ☐ NV PPO 2000 80%
- ☐ NV PPO 3000 80%
- ☐ NV CPOS 500 80%
- ☐ NV CPOS 1000 80%
- ☐ NV CPOS 1500 80%
- ☐ NV CPOS 2000 80%
- ☐ NV CPOS 2500 70%
- ☐ NV CPOS HSA 3000 90%
- ☐ NV PPO HSA 1500 80% (TIF)
- ☐ NV PPO HSA 3000 90%
- ☐ NV PPO HSA 5000 90%
- ☐ NV PPO Saver 5000
- ☐ NV PPO Saver 10,000
- ☐ NV PPO Basic 1500 80%
- ☐ Aetna Value Network HMO $15
- ☐ Aetna Value Network HMO $20
- ☐ Aetna Value Network HMO $25
- ☐ Aetna Value Network HMO $25 GRx
- ☐ **Indemnity**
- ☐ **Mandated Basic HMO**
- ☐ **Mandated Basic PPO**
- ☐ **Mandated Basic Indemnity**
- ☐ **Mandated Standard HMO**
- ☐ **Mandated Standard PPO**
- ☐ **Mandated Standard Indemnity**

B. Life and Disability (available if offered by employer)

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

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

Beneficiary Social Security Number

Relationship to Employee

2. Subscriber Information – *Please complete portion ONLY if a recent change.*

Last Name, First Name, M.I.			Social Security or ID Number
Address (P.O. Box not acceptable)	Apt. No.	City, State	ZIP Code
Home Telephone	Work Telephone	No. of Dependents Including Spouse/Domestic Partner	Spouse/Domestic Partner's Social Security or ID Number
Job Title	Employer Name		No. of Hours Worked Per Week

3. Subscriber/Family Information – *List individuals for whom you are enrolling or adding/changing/removing coverage. Insert additional sheets if necessary. NOTE: Enter Domestic Partner ONLY if your employer has elected that coverage.*

1. Subscriber Name (Last, First, M.I.)					Sex(M/F)	Social Security Number	
Birthdate (MM/DD/YYYY)	Height (ft, in)	Weight (lbs)	Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated	PCP Provider ID Number	Dental Office ID Number		Current Patient **Yes** ☐
2. Spouse/Domestic Partner Name (Last, First, M.I.)			Sex (M/F)	Social Security Number	Relationship ☐ Spouse ☐ Domestic Partner ☐ Other		
Birthdate (MM/DD/YYYY)	Height (ft, in)	Weight (lbs)	Status ☐ Different Last Name	PCP Provider ID Number	Dental Office ID Number		Current Patient **Yes** ☐
3. Child Name (Last, First, M.I.)			Sex (M/F)	Social Security Number	Relationship ☐ Child ☐ Stepchild ☐ Other		
Birthdate (MM/DD/YYYY)	Height (ft, in)	Weight (lbs)	Status ☐ Different Last Name ☐ Lives at another address ☐ Full-Time Student (19+) ☐ Disabled (19+)	PCP Provider ID Number	Dental Office ID Number		Current Patient **Yes** ☐

Continued

3. Subscriber/Family Information *(Continued)*

4. Child Name (Last, First, M.I.)				Sex (M/F)	Social Security Number		Relationship ☐ Child ☐ Stepchild ☐ Other _____
Birthdate (MM/DD/YYYY)	Height (ft, in)	Weight (lbs)	Status ☐ Different Last Name ☐ Lives at another address ☐ Full-Time Student (19+) ☐ Disabled (19+)		PCP Provider ID Number	Dental Office ID Number	Current Patient **Yes** ☐

4. Health History of Members Currently Enrolled* - Provide the required medical information if any enrolled family member has been hospitalized, seen a physician or other health care provider or taken prescription medication within the last 6 months.

***This section is to be completed only for those employees who are requesting to upgrade their benefits.**

Name of Individual	Condition	Medication Prescribed	Dosage	Still Taking Medication
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

5. Conditions of Enrollment

A. I understand and agree that this Change of Coverage Application 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 or 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 Change of Coverage Application, including those involving mental health and substance abuse. 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 these 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, as is any authorized representative that I may designate, to receive a copy of this authorization upon request and that a photocopy is as valid as the original.

B. Authorizations signed for the purposes of collecting information in connection with this form for an insurance policy, a policy reinstatement or a request for a change in policy benefits shall remain valid for thirty (30) months from the date signed. Authorizations signed for the purposes of collecting information in connection with a claim for benefits shall remain valid for the term of this coverage or for so long as allowed by law. The information, as well as other personal or privileged information, subsequently collected by the insurance institution or agent may, in certain circumstances, be disclosed to third parties without authorization. A right of access and correction exists with respect to all personal information collected. Further disclosures required by **Nevada** law will be furnished to the policyholder upon request. Personal information may be collected from persons other than the individual or individuals proposed for coverage.

C. 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.

6. 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 may include imprisonment, fines, denial of insurance and civil damages.

7. Authorization

I represent that all information supplied in this form is true and complete. I have read and agree to the Conditions of Enrollment, Misrepresentation, and Authorization on this **Nevada** Small Group Employee Change of Coverage Application Form.

I understand in the event I fail to sign and return this form within 31 days of my eligibility date 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 30 hours per week for this employer at the regular place of business.

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