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 pages 2 through 4 are not visible.

aetna℠

Pennsylvania Employee Enrollment/Change Form (2 - 100 Eligible Employees)

Group Number
Member Aetna ID Number (if available)

Company 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	☐ New Hire ☐ Waiver ☐ Rehire/Reinstatement ☐ Other ☐ New Group Enrollment _____	☐ 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 ☐ Continuation for: ☐ Employee ☐ Dependent Length of Continuation: ☐ 18 ☐ 36 ☐ Other _____ Original Qualifying Event Date _____ Qualifying Event _____
Date of Hire	☐ Late Enrollment ☐ Open Enrollment			

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

Last Name, First Name, M.I.			Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated
Home Address	Apt. No.	City, State	ZIP Code
Work Address		City, State	ZIP Code
Home Telephone	Work Telephone	Job Title	Primary Language Spoken *(Optional)*

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.*

				Reason for declining coverage	
☐ **Medical declined for:**	☐ Myself	☐ Spouse/Domestic Partner	☐ Child(ren)	☐ Spousal group coverage	☐ COBRA coverage
☐ **Dental declined for:**	☐ Myself	☐ Spouse/Domestic Partner	☐ Child(ren)	☐ Medicare	☐ TRICARE Military coverage
☐ **Life declined for:**	☐ Myself	☐ Spouse/Domestic Partner	☐ Child(ren)	☐ Medicaid	☐ Another group plan provided by my employer
☐ **Disability declined for:**	☐ Myself			☐ Individual coverage	☐ Do not want
				☐ Retiree coverage	
				☐ 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 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. **NOTE:** If your Plan contains a pre-existing conditions provision, the pre-existing conditions exclusion and limitation will not apply to a person under 19 years of age.

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

1. Medical ☐ Yes ☐ No

To enroll, enter plan option elected next to the plan type below:

- ☐ **POS** – Plan Option _____ RX Option _____
- ☐ **POS No Referral** – Plan Option _____ RX Option _____
- ☐ **POS Cost-Sharing** – Plan Option _____ RX Option _____ Plan Administration _____ CalYr _____ Pln Yr
- ☐ **POS Cost-Sharing No Referral** – Plan Option _____ RX Option _____ Plan Administration _____ CalYr _____ Pln Yr
- ☐ **POS HSA Compatible No Referral** – Plan Option: _____
- ☐ **PPO** – Plan Option _____ RX Option _____
- ☐ **PPO Cost-Sharing** – Plan Option _____ RX Option _____ Plan Administration _____ CalYr _____ Pln Yr
- ☐ **PPO HSA Compatible** – Plan Option: _____
- ☐ **Health Network Option AHF HRA** – Plan Option _____
- ☐ **Indemnity** – Plan Option: _____
- ☐ **Other Plan** – Plan Option _____

Control/Group No.	Suffix	Account	Plan No.

2. Dental ☐ Yes ☐ No

To enroll, enter plan number and name elected below.

Contributory Plan:
Plan Number: _____
Plan Name: _____
If Freedom-of-Choice, check: ☐ DMO® *or* ☐ PPO

Voluntary Plans:
Plan Number: _____
Plan Name: _____
If Freedom of Choice, check: ☐ 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

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

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

Beneficiary Social Security Number

Relationship to Employee

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

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.

1. Employee Name (Last, First, M.I.)					Sex (M/F)	Social Security Number
Birthdate (MM/DD/YYYY)	Height (ft, in)	Weight (lbs)	Coverage Election ☐ Medical ☐ Dental ☐ Life/Disability	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
Birthdate (MM/DD/YYYY)	Height (ft, in)	Weight (lbs)	Coverage Election ☐ Medical ☐ Dental ☐ Life	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) ☐ Disability	Height (ft, in)	Weight (lbs)	Coverage Election ☐ Medical ☐ Dental ☐ Life	PCP Provider ID Number	Dental Office ID Number	Current Patient **Yes** ☐

4. Child Name (Last, First, M.I.)				Sex (M/F)	Social Security Number	Relationship ☐ Child ☐ Stepchild ☐ Other _____
Birthdate (MM/DD/YYYY) ☐ Disability	Height (ft, in)	Weight (lbs)	Coverage Election ☐ Medical ☐ Dental ☐ Life	PCP Provider ID Number	Dental Office ID Number	Current Patient **Yes** ☐

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.)

Check all that apply to Employee and Dependents enrolling for coverage: ☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05

F. Dependent Information

List any dependent in Section **D** living at another address.	Name:	Reason:	Address:
If any dependent's last name differs from yours, explain.	Name:	Reason:	

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

G. Other Insurance

Does anyone age 19 and over enrolling on this enrollment form have prior medical coverage? ☐ Yes ☐ No If "Yes," please provide information requested in the grid below.

Proof of coverage should accompany this enrollment form for pre-existing condition credit.

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 (age 19 and over) 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. NOTE: If your Plan contains a pre-existing conditions provision, the pre-existing conditions exclusion and limitation will not apply to a person under 19 years of age.

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

H. Medicare Information

Name of Person	Medicare Part A	Medicare Part B	Medicare Part C	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	☐ Yes ☐ No	☐ Yes ☐ No	

I. Health Questionnaire for Groups with 2 – 50 Eligible Employees (or 2 - 100 if enrolling for life above the Guarantee Issue amount).

Health History for Employees 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 or your dependents or the enrollment form will be returned.
- Incomplete enrollment forms may delay the effective date of your coverage.

1. Within the last **5** 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

☐ AIDS or HIV	☐ Heart Disorder/Disease	☐ Birth Defects/Congenital Abnormalities
☐ Diabetes	☐ Tumor/Cyst/Growth	☐ Arthritis/Bone/Joint/Muscle/Prosthetic Device
☐ Infertility	☐ Systemic or Discoid Lupus	☐ Mental/Nervous/Emotional/Eating Disorder
☐ Endocrine/Metabolic	☐ Lung or Respiratory	☐ Stroke/Brain/Neurological
☐ Pancreas	☐ Alcohol or Drug Use	☐ Transplant: ☐ Recommended ☐ Pending ☐ Complete
☐ Liver/Hepatitis	☐ Kidney/Bladder/Urinary	☐ Advised to have tests, surgery, hospitalization or treatment
☐ Immune System	☐ Circulatory/Vascular	is needed, or course of treatment not yet determined
☐ Blood Disorder	☐ Digestive/Stomach/Intestinal	☐ Cancer: Type: _____ Stage _____
☐ Hemophilia	☐ Central Nervous System	☐ Surgery ☐ Chemo ☐ Radiation
☐ Epilepsy/Seizure	☐ Connective Tissue Disorder	☐ Using: ☐ Crutches ☐ Walker ☐ Wheelchair
☐ Paralysis/Paresis	☐ Pituitary/Adrenal/Growth Disorder	☐ Known condition that requires on-going treatment?

2. Is any female currently pregnant? If "Yes," provide due date _____ Check applicable boxes: ☐ Yes ☐ No
☐ C section planned ☐ Multiple Births Expected (# _____) ☐ Complications: ☐ Past or ☐ Present

3. Have you or your spouse (if enrolling) smoked cigarettes in the past 12 months? If "Yes," who: ☐ Employee ☐ Spouse ☐ Yes ☐ No

4. Has anyone applying for coverage incurred medical expenses in excess of $5,000 in the past 24 months? ☐ Yes ☐ No

5. Has anyone applying for coverage been prescribed medications in the past 12 months? ☐ Yes ☐ No

6. Has anyone applying for coverage been hospitalized or had a surgical procedure in the past 24 months? ☐ Yes ☐ No

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

J. Health Questionnaire – Details for "Yes" Responses in Section I.

Ques No.	Name of Individual	Condition/Diagnosis/Treatment	Date of Onset	Date Treatment Ended	Name of Prescription Medication(s)	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
							☐ Yes ☐ No
							☐ Yes ☐ No

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 Page 2, 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 & 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 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. 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. 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 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.
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. **NOTE**: If your Plan contains a pre-existing conditions provision, the pre-existing conditions exclusion and limitation will not apply to a person under 19 years of age.

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 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		