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.

aetna℠

Arizona Group Business Employee Change of Coverage Form

(For Existing Enrollees 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 Group benefit coverage.

1. **You, the employee, must complete this form.** 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 form 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

1. Medical - Check one.

- ☐ **HMO** 15/30/250
- ☐ **HNO:** ☐ 750 80/60 ☐ 1000 80/60 ☐ 1500 70/50
- ☐ **PPO:** ☐ 500 80/60 ☐ 1000 70/50 ☐ 2500 80/60 ☐ 750 80/60 ☐ 2000 70/50 ☐ 5000 80/60 ☐ 1000 80/60
- ☐ **PPO 100%:** ☐ 2500 100/50 ☐ 5000 100/50 ☐ 3500 100/50
- ☐ **PPO Value:** ☐ Value: 2500 80/50 ☐ Value Saver: 7500 100/50 ☐ Value Saver: 10,000 100/50
- ☐ **CDHP**: ☐ HSA HDHP 2500 90/50 ☐ HSA HDHP 4000 80/50 ☐ HSA HDHP 2500 100/50 ☐ HSA HDHP 5000 100/50
- ☐ **Savings Plus:** ☐ Savings Plus 750 80/60 ☐ Savings Plus 1000 70/50 ☐ Savings Plus 2000 70/50 ☐ Savings Plus HSA HDHP 2500 100/50 ☐ Savings Plus HSA HDHP 4000 80/50 ☐ Savings Plus Value Saver 10,000 100/50
- ☐ **Aetna Whole Health:** ☐ Banner Health Network 750 80/60 ☐ Banner Health Network 1000 70/50 ☐ Banner Health Network 2000 70/50 ☐ Banner Health Network HSA HDHP 2500 100/50 ☐ Banner Health Network HSA HDHP 4000 80/50 ☐ Banner Health Network Value Saver 10,000 100/50
- ☐ **Indemnity 500 80%**

Control/Group No.	Suffix	Account	Plan No.

2. Dental - Check one (if applicable).

Standard Plans:

☐ Aetna Dental® Plan – Plan Option: _____

For *FOC, choose:* ☐ DMO® or ☐ PPO

Voluntary Plans:

☐ Aetna Dental® Plan – Plan Option: _____

For *FOC, choose:* ☐ 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

2 – 50 size groups:

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

☐ Optional Dependent Life

51 – 100 size groups: See specific employee application for Life & Disability coverages.

Beneficiary Designation - **Full Name** (First, Middle, Last)
Beneficiary Social Security Number
Relationship to Employee

2. Employee 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	Spouse Social Security or ID Number
Job Title	Employer Name		No. of Hours Worked Per Week

3. Employee/Family Information – ***List individuals for whom you are enrolling or adding/changing/removing coverage. Insert additional sheets if necessary. If spouse's last name is different from yours, is he/she a domestic partner?*** ☐ Yes ☐ No

NOTE FOR MEDICAL AND DENTAL COVERAGE: While the Federal Patient Protection and Affordable Care Act mandates coverage of dependents 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.

Name (Last, First, M.I.)	Sex M/F	Social Security Number	Relationship	Birthdate (MM/DD/YYYY)	Height (ft., in.)	Weight (lbs.)	Status	PCP Provider ID Number	Current Patient	Dental Office ID Number (if applicable)	Current Patient
a. Self							☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated		**Yes** ☐		**Yes** ☐
b. Spouse/Domestic Partner			☐ Spouse ☐ Other _____				☐ Different Last Name		☐		☐
c. Child			☐ Child ☐ Stepchild ☐ Other _____				☐ Different Last Name ☐ Lives at another address ☐ Full-time student-Life only ☐ Disabled		☐		☐
d. Child			☐ Child ☐ Stepchild ☐ Other _____				☐ Different Last Name ☐ Lives at another address ☐ Full-time student-Life only ☐ Disabled		☐		☐
e. Child			☐ Child ☐ Stepchild ☐ Other _____				☐ Different Last Name ☐ Lives at another address ☐ Full-time student-Life only ☐ Disabled		☐		☐

4. Health History of Members Currently Enrolled* - Please complete the Uniform Employee Health Status Questionnaire, which can be found at www.id.state.az.us/consumerbusiness.html#health.

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

5. Conditions of Enrollment

1. I understand and agree that this Change of Coverage 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 or pharmacy 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 Form, 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.
2. 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 **Arizona** 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.
3. 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. Authorization

I represent that all information supplied in this form is true and complete. I have read and agree to the Conditions of Enrollment and Authorization on this **Arizona** Group Business Employee Change of Coverage 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.

Employee Signature	***Employee E-mail Address (optional)***	***Date (Month/Day/Year)***
X		