aetna℠

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

Aetna Member ID Number

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 D.**

Effective Date

Date of Hire

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

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

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

Last Name, First Name, M.I.			Home Telephone
Home Address	Apt. No.	City, State	ZIP Code
Work Address	City, State	ZIP Code	Work Telephone

Job Title	Number of Hours Worked Per Week	Check One	Marital Status	Primary Language Spoken (optional)
		☐ Full-Time ☐ Part-Time ☐ 1099 ☐ Seasonal ☐ Retiree ☐ Temporary	☐ Single ☐ Divorced ☐ Married ☐ Widowed ☐ Legally Separated	

B. Coverage Selection – *Please print clearly, using black ink. (Top boxes for Employer/Aetna-Use Only.)*

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

1. Medical – *To enroll, enter the plan option elected next to the plan type below.*

- ☐ Health Network Only
  Plan Option: _____
- ☐ Health Network Only HSA Compatible
  Plan Option: _____
- ☐ HMO HSA Compatible
  Plan Option: _____
- ☐ Health Network Option HSA Compatible
  Plan Option: _____
- ☐ PPO - Plan Option: _____
- ☐ PPO Consumer Directed
  Plan Option: _____
- ☐ PPO HSA Compatible
  Plan Option: _____
- ☐ Comprehensive Standard Health Benefit Plan
  Product / Plan Option: _____
- ☐ Matching POS – Plan Option: _____
- ☐ Other Plan – Plan Option: _____

Control/Group No.	Suffix	Acct	Plan No.

2. Aetna Dental® Plans – *To enroll, enter the plan number and name elected below.*

Contributory Plans:

Plan Number: _____
Plan Name: _____
If FOC, choose: ☐ DMO® *or* ☐ PPO

Voluntary Plans:

Plan Number: _____
Plan Name: _____
If FOC, choose: ☐ DMO® *or* ☐ PPO

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

The Aetna Dental DMO® plan, including the DMO component of the Freedom-of-Choice plan design option, is underwritten by Aetna Dental Inc. The Aetna Dental PPO plans, including the Consumer Directed plan design and the PPO component of the Freedom-of-Choice plan design option, are underwritten by Aetna Life Insurance Company.

Control/Grp No.	Suffix	Acct	Plan No.

3. Life and Disability

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

Life, Accidental Death & Dismemberment, and Disability plans are underwritten by Aetna Life Insurance Company.

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

Beneficiary Social Security Number

Relationship to Employee

Aetna HMO/Health Network Only plans, including the in-network component of the POS/Health Network Option plans, are underwritten by Aetna Health Inc. The out-of-network component of the Aetna POS/Health Network Option plans is underwritten by Aetna Health Insurance Company. All Aetna PPO and Indemnity plans are underwritten by Aetna Life Insurance Company.

C. Corporate Headquarters

Aetna Health Inc.	**Aetna Health Insurance Company**	**Aetna Life Insurance Company**	**Aetna Dental Inc.**
980 Jolly Road Blue Bell, PA 19422	980 Jolly Road Blue Bell, PA 19422	151 Farmington Avenue Hartford, CT 06156	1 Prudential Circle – 4th Floor Sugar Land, TX 77478

Please do not address any correspondence to the addresses above. Please address correspondence (including this completed form) to:
Aetna Small Group Underwriting, Mail Stop F602 , 841 Prudential Drive, Jacksonville, FL 32207

D. 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.***

☐ **Medical Coverage declined for:** ☐ Myself ☐ Spouse/Domestic Partner ☐ Child(ren) ☐ **Dental Coverage declined for:** ☐ Myself ☐ Spouse/Domestic Partner ☐ Child(ren)	**Reason for Declining Coverage** ☐ Spouse/Domestic Partner group coverage ☐ COBRA coverage ☐ Medicare ☐ Medicaid ☐ Individual coverage ☐ Other _____ ☐ Parental group coverage ☐ TRICARE Military coverage ☐ Retiree coverage ☐ Another group plan provided by my employer ☐ Do not want

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.

Please sign here ONLY if you are declining coverage for yourself and/or your dependent(s).	***Date (Month/Day/Year)***
Employee Signature X	

E. 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. 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		
Birth date (MM/DD/YYYY)	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 ☐ Other _____	
Birth date (MM/DD/YYYY)	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 _____	
Birth date (MM/DD/YYYY)	Disability **Yes** ☐	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 _____	
Birth date (MM/DD/YYYY)	Disability **Yes** ☐	Coverage Election ☐ Medical ☐ Dental ☐ Life		PCP Provider ID Number	Dental Office ID Number	Current Patient **Yes** ☐

F. Dependent Information

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

FOR DEPENDENT LIFE: If applying for life coverage and age 19 and over and a full-time student, provide the following:

Child Name	School Name	Expected Graduation Date	Number of Credit Hours

G. 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

H. Medicare Information

Name of Person	Medicare Part A	Medicare Part B	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	

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 coverage, for the plans I selected in the Coverage Selection section on Page 1 of this form, is provided by the entities described in that section. These entities are collectively referred to as "Aetna".
2. I understand and agree that my employer's application will determine coverage and that, except for medical coverage, there is no coverage unless and until both the eligible employee enrollment form and 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 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, except that for medical coverage, no statement or omission will be used to contest the validity of the coverage after the coverage has been in effect for two (2) years.
   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 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") to give to Aetna or its agent information concerning the medical history, services or treatment provided to anyone listed on this Enrollment 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/domestic partner 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, 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 the exception of direct access services and emergency procedures as defined 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.

Misrepresentation

7. Any person who knowingly or willfully presents a false or fraudulent claim for the payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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 **Maryland** 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 30 or more hours per week on a full time basis or, if part time coverage is offered, at least 17.5 hours per week and as required by this employer at the regular place of business. **If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a Member Services representative before signing this enrollment form.**

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