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 health information is not visible.

aetna®

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

TO COMPLY WITH CALIFORNIA LAW WHEREVER THE TERM "SPOUSE" APPEARS IT SHALL BE CONSTRUED TO INCLUDE DOMESTIC PARTNER.

Coverage is provided by the following entities: Aetna Health of California Inc. for HMO, Aetna Dental of California Inc. for Dental (DMO® only) and Aetna Life Insurance Company for all other coverages.

Group Number

Applicant Social Security 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 enrolling, please be sure to sign and date Employee Signature on Page 4. If waiving coverage, please complete Section B and Declination/Waiver of Coverage on Page 5 only.**			
Effective Date **Date of Hire**	☐ New Hire ☐ Rehire/Reinstatement ☐ New Group Enrollment ☐ Late Enrollment ☐ Other _____	☐ Add Spouse/Dependent Child ☐ Change of Coverage ☐ Name Change ☐ Other _____	☐ Employee Termination ☐ Remove Spouse/ Dependent Child ☐ Cancel Coverage	☐ COBRA ☐ Cal-COBRA for: ☐ Employee ☐ Dependent Length of Continuation: ☐ 18 ☐ 36 ☐ Other ____ Original Qualifying Event Date _____ Loss of Coverage Date _____

A. Coverage Selection – ***Please print clearly, using black ink. (Shaded sections for Employer/Aetna Use Only)***

Control/Group No.	Suffix	Account	Plan No.	Class Code
1. Medical				
PLAN NAME	**Networks**			
Select Plan Option(s) and then check the box(es) for the Networks you choose for each Plan.				
☐ Platinum Vitalidad HMO 25	☐ Vitalidad HMO			
☐ Platinum HMO Copay Plan	☐ HMO			
☐ Gold HMO 10	☐ HMO	☐ AVN HMO	☐ Basic HMO	☐ PrimeCare
☐ Gold HMO 20	☐ HMO	☐ AVN HMO	☐ Basic HMO	
☐ Gold HMO 30	☐ HMO	☐ AVN HMO	☐ Basic HMO	☐ PrimeCare
☐ Gold HMO Copay Plan	☐ HMO	☐ AVN HMO	☐ Basic HMO	
☐ Silver HMO Deductible 1000	☐ Basic HMO	☐ HMO DED	☐ PrimeCare	
☐ Silver HMO Deductible 1500	☐ Basic HMO	☐ HMO DED		
☐ Silver HMO Deductible 2000	☐ Basic HMO	☐ HMO DED	☐ PrimeCare	
☐ Silver HMO Deductible Copay	☐ HMO DED			
☐ Bronze HMO Deductible 5500	☐ Basic HMO	☐ HMO DED	☐ PrimeCare	
☐ Platinum MC Copay Plan	☐ MC			
☐ Gold MC 500 80/50	☐ MC	☐ Savings Plus		
☐ Gold MC Copay Plan	☐ MC			
☐ Silver MC Coinsurance Plan	☐ MC			
☐ Silver MC 1000 75/50	☐ MC	☐ Savings Plus		
☐ Silver MC 1000 60/50	☐ MC	☐ Savings Plus	☐ PrimeCare	
☐ Silver MC 1500 60/50	☐ MC	☐ Savings Plus	☐ PrimeCare	
☐ Silver MC 2000 60/50	☐ MC	☐ Savings Plus		
☐ Silver MC Coinsurance Plan	☐ MC			

A. Coverage Selection *(continued)*

1. Medical - *continued*

PLAN NAME	Networks			
☐ Bronze MC 3500 50/50	☐ MC	☐ Savings Plus		
☐ Bronze MC 4000 Copay Plan	☐ MC	☐ Savings Plus		
☐ Bronze MC 6350 100/50	☐ MC	☐ Savings Plus	☐ PrimeCare	
☐ Bronze MC Plan	☐ MC			
☐ Bronze MC HSA 2500 50/50	☐ MC	☐ Savings Plus		
☐ Bronze MC HSA 3500 70/50	☐ MC	☐ Savings Plus	☐ PrimeCare	
☐ Bronze MC HSA 6300 100/50	☐ MC	☐ Savings Plus	☐ PrimeCare	
☐ Gold PPO 750	☐ PPO			
☐ Silver Indemnity				

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 (if applicable)

☐ Basic Life/AD&D Ultra® ☐ Optional Dependent Life

Full Beneficiary Name (First, Middle, Last)	Beneficiary Social Security Number	Birthdate (MM/DD/YYYY) / /

Beneficiary Address (Number, Street, **Apt. No.**, City, State, ZIP Code)	Telephone Number ( ) -	Relationship to Employee

B. Employee Information – ***Must be completed by the employee.***

Member Aetna ID Number (if available)	Last Name, First Name, M.I.		
Home Address (PO Box not acceptable)	Apt. No.	City, State	ZIP Code
Work Address (PO Box not acceptable)		City, State	ZIP Code

Home Telephone	Work Telephone	Primary Language Spoken (Optional)	Number of Dependents enrolling for coverage including Spouse

Salary $ _____	☐ Hourly ☐ Monthly ☐ Weekly	Number of Hours Worked Per Week	Check One: ☐ Full-Time ☐ Part-Time ☐ 1099 ☐ Retiree ☐ Seasonal ☐ Temporary ☐ Union	Job Title

C. Individuals Covered - ***List individuals for whom you are enrolling or adding/changing/removing coverage. Insert additional sheets if necessary. For dependents with different last names or living at another address, complete Section D below.*** **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	Birthdate (MM/DD/YYYY) / /

Status ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated	Coverage Election ☐ Medical ☐ Dental ☐ Life	PCP Provider Office ID Number	Current Patient ☐	Dental Office ID Number (if applicable)	Current Patient ☐

2	**Name** (Last, First, M.I.)	Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /

Relationship ☐ Spouse ☐ Other _____	Coverage Election ☐ Medical ☐ Dental ☐ Life	PCP Provider Office ID Number	Current Patient ☐	Dental Office ID Number (if applicable)	Current Patient ☐

continued on next page

C. Individuals Covered *(continued)*

3	**Child Name** (Last, First, M.I.)	Sex (M/F)	Social Security Number		Birthdate (MM/DD/YYYY) / /	
Relationship ☐ Child ☐ Stepchild ☐ Other _____	Coverage Election ☐ Medical ☐ Dental ☐ Life	PCP Provider Office ID Number	Current Patient ☐	Dental Office ID Number (if applicable)	Current Patient ☐	
4	**Child Name** (Last, First, M.I.)	Sex (M/F)	Social Security Number		Birthdate (MM/DD/YYYY) / /	
Relationship ☐ Child ☐ Stepchild ☐ Other _____	Coverage Election ☐ Medical ☐ Dental ☐ Life	PCP Provider Office ID Number	Current Patient ☐	Dental Office ID Number (if applicable)	Current Patient ☐	
5	**Child Name** (Last, First, M.I.)	Sex (M/F)	Social Security Number		Birthdate (MM/DD/YYYY) / /	
Relationship ☐ Child ☐ Stepchild ☐ Other _____	Coverage Election ☐ Medical ☐ Dental ☐ Life	PCP Provider Office ID Number	Current Patient ☐	Dental Office ID Number (if applicable)	Current Patient ☐	
6	**Child Name** (Last, First, M.I.)	Sex (M/F)	Social Security Number		Birthdate (MM/DD/YYYY) / /	
Relationship ☐ Child ☐ Stepchild ☐ Other _____	Coverage Election ☐ Medical ☐ Dental ☐ Life	PCP Provider Office ID Number	Current Patient ☐	Dental Office ID Number (if applicable)	Current Patient ☐	

D. Dependent Information

List any dependent in Section **C** living at another address.

Name	Address

For Dependent Life: If age 19 and over and a full-time student, provide information below.

Child Name	School Name	Expected Graduation Date	Number of Credit Hours

E. Coordination of Benefits

Will you have other health insurance at the same time as this coverage? ☐ Yes ☐ No

Name of Person	Carrier Name	Name of Person	Carrier Name

Conditions of Enrollment

NOTICE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

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: Aetna Health of California Inc.
   - Aetna Dental DMO: Aetna Dental of California Inc.
   - Life, Accidental Death & Personal Loss, Dental and all other health 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 misstatements or omissions may result in future claims being denied and the policy or my coverage under the policy being reevaluated, as of the effective date, for eligibility and rating purposes. **For life 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"), including pharmacies or pharmacy database benefit managers to give to 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 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. I understand that this authorization is provided under state law, and that it is not an "authorization" within the meaning of the federal Health Insurance Portability and Accountability Act. This authorization is valid for 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.

Misrepresentation

7. **Attention California Residents**: **For your protection, California law requires notice of the following to appear on this form:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

To the best of my knowledge, 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 **California** Small Group Business (2 - 50 Eligible Employees) Employee Enrollment/Change 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.

CA HMO ENROLLEES - NOTICE OF BINDING ARBITRATION: ANY DISPUTE ARISING FROM OR RELATED TO HEALTH PLAN MEMBERSHIP WILL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION, AND NOT BY A LAWSUIT OR RESORT TO COURT PROCESS EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. THE AGREEMENT TO ARBITRATE INCLUDES, BUT IS NOT LIMITED TO, DISPUTES INVOLVING ALLEGED PROFESSIONAL LIABILITY OR MEDICAL MALPRACTICE, THAT IS, WHETHER ANY MEDICAL SERVICES COVERED BY THIS AGREEMENT WERE UNNECESSARY OR WERE UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED. THE HEALTH PLAN AGREEMENT ALSO LIMITS CERTAIN REMEDIES AND MAY LIMIT THE AWARD OF PUNITIVE DAMAGES. SEE THE EVIDENCE OF COVERAGE FOR FURTHER INFORMATION.

I understand that I am giving up the constitutional right to have disputes decided in a court of law before a jury, and instead am accepting the use of binding arbitration. This means that members will not be able to try their case in court. I further understand that the agreement contains limitations on certain remedies and that there may be certain limitations to the recovery of punitive damages.

☐ **I AM ENROLLING FOR COVERAGE:** ***Employee Signature*** **X**	***Employee E-mail Address (optional)***	***Date (Month/Day/Year)***

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.***

I understand I am eligible to apply for this coverage through my employer; however, I am waiving coverage as noted below.

☐ Employee: ☐ Medical ☐ Dental ☐ Life	**Reason for declining coverage**
☐ Spouse ☐ Medical ☐ Dental ☐ Life	☐ Spousal group coverage ☐ Insurance through another job ☐ Parental group coverage ☐ TRICARE ☐ COBRA coverage ☐ VA coverage ☐ Medicare ☐ Individual coverage - On or Off Exchange ☐ Medi-Cal ☐ Do not want ☐ Retiree coverage ☐ Other _____ ☐ Another group plan provided by my employer
☐ Child(ren): ☐ Medical ☐ Dental ☐ Life	

I certify 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 I 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)***
☐ I AM DECLINING COVERAGE: **Employee Signature** **X**	

DMHC Written Notice of Availability of Language Assistance

HMO and DMO-based plans - **IMPORTANT:** Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-877-287-0117.

Planes basados en DMO y HMO - **IMPORTANTE:** ¿Puede leer esta carta? En caso de no poder leerla, le brindamos nuestra ayuda. También puede obtener esta carta escrita en su idioma. Para obtener ayuda gratuita, por favor llame de inmediato al 1-877-287-0117.

Traditional Plans:

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-877-287-0117. For more help call the CA Dept. of Insurance at 1-800-927-4357 English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-877-287-0117. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

免費語言服務。您可獲得口譯員服務，用中文把文件唸給您聽。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打 1-877-287-0117 與我們聯絡。欲取得其他協助，請致電1-800-927-4357 與加州保險部聯絡。Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch và được người khác đọc giúp các tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-877-287-0117 . Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese.

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-877-287-0117번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-877-287-0117. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-877-287-0117 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-877-287-0117. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または1-877-287-0117までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Japanese

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره 1-877-287-0117 تماس بگیرید. برای دریافت کمک بیشتر، به اداره بیمه کالیفرنیا (CA Dept. of Insurance) به شماره 1-800-927-4357 تلفن کنید. Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-877-287-0117 'ਤ ਸਾਨ ਫ਼ਨ ਕਰੋ। ਵਧੇਰ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

ជេអាចមួយភាសាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមាន បង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-877-287-0117 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងមានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-877-287-0117 . للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357 Arabic.

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-877-287-0117. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

CDI Notice of Language Assistance-Trad