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 coverage.

Small Group Employee Change of Coverage Application – CA

(For Existing Enrollments Only)

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

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.	Control/Group No.	Suffix	Account	Plan No.

1. Medical - Check one.

HMO: ☐ 10/20 ☐ 10/30 ☐ 20/40 ☐ 30/40 ☐ HRA 750 25 ☐ HRA 1500 40 ☐ Deductible 1000 40

Aetna Value Network℠ HMO: ☐ 10/20 ☐ 20/40 ☐ 30/40

Vitalidad Mexico HMO: ☐ 5 ☐ 10

EPO: ☐ EPO 80 ☐ EPO Limited

MC: ☐ 250 90/70 ☐ 250 80/60 ☐ 500 80/60 ☐ 1000 80/50/50 ☐ 1000 70/50 ☐ 2000 80/50/50 ☐ Basic ☐ HRA HDHP 3000 80/50 ☐ HRA HDHP 5000 80/50 ☐ HSA HDHP 2300 80/50 ☐ HSA HDHP 3000 100/50 ☐ HSA HDHP 3300 80/50

PPO: ☐ 500 90/70

☐ **Aetna Indemnity** ☐ **Out-of-State**

2. Dental - Check one. (if applicable)

Standard Plans:

☐ **1** - DMO® Access
☐ **2** - DMO® Plus (Plan 58)
☐ **3** - Freedom-of-Choice Basic: ☐ DMO® or ☐ PPO
☐ **4** - Freedom-of-Choice Plus: ☐ DMO® or ☐ PPO
☐ **5** - PPO 1000 Active
☐ **6** - PPO 1500
☐ **7** - PPO 1500 Active
☐ **8** - PPO 2000
☐ Out-of-State PPO

Voluntary Plans:

☐ Option **V1** - DMO® Access
☐ Option **V2** - DMO® Plus (Plan 58)
☐ Option **V3** - PPO 1000 Active
☐ Option **V4** - PPO 1500
☐ Option **V5** - PPO 1500 Active
☐ Out-of-State PPO

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

3. Life

☐ Basic Life/AD&D Ultra™
☐ 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	Spouse'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. If spouse's last name is different from yours, is he/she a domestic partner?*** ☐ Yes ☐ No

1. Self 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 Office ID Number	Current Patient **Yes** ☐	Dental Office ID Number (if applicable)	Current Patient **Yes** ☐

2. Spouse Name (Last, First, M.I.)			Sex (M/F)	Social Security Number	Relationship ☐ Spouse ☐ Other _____		
Birthdate (MM/DD/YYYY)	Height (ft, in)	Weight (lbs)	Status ☐ Different Last Name	PCP Provider Office ID Number	Current Patient **Yes** ☐	Dental Office ID Number (if applicable)	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 Office ID Number	Current Patient **Yes** ☐	Dental Office ID Number (if applicable)	Current Patient **Yes** ☐

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 Office ID Number	Current Patient **Yes** ☐	Dental Office ID Number (if applicable)	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.

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

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

5. Misrepresentation

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.

6. Authorization

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 Authorization Conditions of Enrollment and Misrepresentation on this **California** 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.

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.

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