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®

Arizona Group Business Employee Enrollment/Change Form (51-100 Eligible Employees)

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 B and G.**

Group Number
Member Aetna ID Number (if available)

Company Name

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

A. Coverage Selection – ***Please print clearly, using black ink.***

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

1. Medical - Check one.

☐ **HMO** - Plan Option: _____
☐ **HNO** - Plan Option: _____
☐ **PPO** - Plan Option: _____
☐ **Indemnity** - Plan Option: _____
☐ **Savings Plus** - Plan Option: _____
☐ **Aetna Whole Health/Arizona Care** - Plan Option: _____
☐ **Aetna Whole Health/Banner –** Plan Option _____

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

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

3. Life and Disability See specific employee application for Life and Disability coverages.

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

Social Security Number	Last Name, First Name, M.I.	Job Title	Home Telephone

Home Address	Apt. No.	City, State	ZIP Code

Work Address	City, State	ZIP Code	Work Telephone

Salary (Complete only if enrolling for Life or Disability) $	Primary Language Spoken (Optional)	Number of Hours Worked Per Week	Check One:	Number of Dependents Excluding Self
☐ Hourly ☐ Monthly ☐ Weekly			☐ Full-Time ☐ Part-Time ☐ 1099 ☐ Seasonal ☐ Retiree ☐ COBRA ☐ Union ☐ Temporary	

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

1	(**A**)dd (**C**)hange ___ (**R**)emove	**Employee Name** (Last, First, M.I.)			Sex (M/F)	Social Security Number		Birthdate (MM/DD/YYYY)		
Status ☐ Single ☐ Divorced ☐ Married ☐ Widowed ☐ Legally Separated		Coverage Election ☐ Medical ☐ Dental ☐ Life/Dis	Other Dental Coverage **Yes** ☐	Prior Dental Coverage **Yes** ☐	Primary Office ID # (If applicable)	Current Patient **Yes** ☐	Dental Office ID # (If applicable)	Current Patient **Yes** ☐		
2	(**A**)dd (**C**)hange ___ (**R**)emove	**Name** (Last, First, M.I.) ☐ **Spouse** ☐ **Domestic Partner**			Sex (M/F)	Social Security Number		Birthdate (MM/DD/YYYY)		
Status ☐ Different last name		Coverage Election ☐ Medical ☐ Dental ☐ Life	Other Dental Coverage **Yes** ☐	Prior Dental Coverage **Yes** ☐	Primary Office ID # (If applicable)	Current Patient **Yes** ☐	Dental Office ID # (If applicable)	Current Patient **Yes** ☐		
3	(**A**)dd (**C**)hange ___ (**R**)emove	**Name** (Last, First, M.I.) ☐ **Child** ☐ **Stepchild** ☐ **Other**			Sex (M/F)	Social Security Number		Birthdate (MM/DD/YYYY)		
Status ☐ Different last name ☐ Lives at another address ☐ Full-time Student–Life Only ☐ Incapacitated		Coverage Election ☐ Medical ☐ Dental ☐ Life	Other Dental Coverage **Yes** ☐	Prior Dental Coverage **Yes** ☐	Primary Office ID # (If applicable)	Current Patient **Yes** ☐	Dental Office ID # (If applicable)	Current Patient **Yes** ☐		
4	(**A**)dd (**C**)hange ___ (**R**)emove	**Name** (Last, First, M.I.) ☐ **Child** ☐ **Stepchild** ☐ **Other**			Sex (M/F)	Social Security Number		Birthdate (MM/DD/YYYY)		
Status ☐ Different last name ☐ Lives at another address ☐ Full-time Student–Life Only ☐ Incapacitated		Coverage Election ☐ Medical ☐ Dental ☐ Life	Other Dental Coverage **Yes** ☐	Prior Dental Coverage **Yes** ☐	Primary Office ID # (If applicable)	Current Patient **Yes** ☐	Dental Office ID # (If applicable)	Current Patient **Yes** ☐		
5	(**A**)dd (**C**)hange ___ (**R**)emove	**Name** (Last, First, M.I.) ☐ **Child** ☐ **Stepchild** ☐ **Other**			Sex (M/F)	Social Security Number		Birthdate (MM/DD/YYYY)		
Status ☐ Different last name ☐ Lives at another address ☐ Full-time Student–Life Only ☐ Incapacitated		Coverage Election ☐ Medical ☐ Dental ☐ Life	Other Dental Coverage **Yes** ☐	Prior Dental Coverage **Yes** ☐	Primary Office ID # (If applicable)	Current Patient **Yes** ☐	Dental Office ID # (If applicable)	Current Patient **Yes** ☐		
6	(**A**)dd (**C**)hange ___ (**R**)emove	**Name** (Last, First, M.I.) ☐ **Child** ☐ **Stepchild** ☐ **Other**			Sex (M/F)	Social Security Number		Birthdate (MM/DD/YYYY)		
Status ☐ Different last name ☐ Lives at another address ☐ Full-time Student–Life Only ☐ Incapacitated		Coverage Election ☐ Medical ☐ Dental ☐ Life	Other Dental Coverage **Yes** ☐	Prior Dental Coverage **Yes** ☐	Primary Office ID # (If applicable)	Current Patient **Yes** ☐	Dental Office ID # (If applicable)	Current Patient **Yes** ☐		

D. Dependent Information

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

Name	Address

For Life Only: If age 19 and over and a full-time student, provide the following:

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**

F. 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	

G. 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.***

☐ Employee:	☐ Medical ☐ Life	☐ Dental ☐ Disability
☐ Spouse/ Domestic Partner:	☐ Medical ☐ Life	☐ Dental
☐ Child(ren):	☐ Medical ☐ Life	☐ Dental

Reason for declining coverage

- ☐ Spousal/Domestic Partner group coverage
- ☐ Parental group coverage
- ☐ Medicare
- ☐ Medicaid
- ☐ Retiree coverage
- ☐ Another group plan provided by my employer
- ☐ COBRA coverage
- ☐ Insurance through another job
- ☐ TRICARE Military coverage
- ☐ AHCCCS
- ☐ Indian Health Services
- ☐ Individual coverage – On Exchange
- ☐ Individual coverage – Off Exchange
- ☐ Do not want
- ☐ 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 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 or dependent(s). **Employee Signature** X	***Date (Month/Day/Year)***

Conditions of Enrollment

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 and Aetna HNO plans: Aetna Health Inc., Aetna Health Insurance Company and/or Aetna Life Insurance Company.
   - Aetna PPO plans, Aetna CDHP-HSA plans, Aetna Savings Plus plans and Aetna Whole Health plans: Aetna Life Insurance Company.
   - Life, Accidental Death & Personal Loss, disability, dental (except DMO®) and all other coverages: Aetna Life Insurance Company. DMO® dental coverage is provided by Aetna Health Inc.
2. I understand and agree that my employer's enrollment form 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 rescinded or reevaluated, as of the effective date, for eligibility and 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 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 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 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, 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.

continued on next page

Conditions of Enrollment *(continued)*

4. Authorizations signed for the purpose of collecting information in connection with this enrollment form for an insurance policy, a policy reinstatement or a request for changes in policy benefits shall remain valid for thirty (30) months from the date signed. Authorization signed for the purpose 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.
5. 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. 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.
7. 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.

I represent that all information supplied in this form is true and complete. I have read and agree to the Conditions of Enrollment on this **Arizona** Group Business 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 at the regular place of business.

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