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 pages 2 and 3 are not visible.

Aetna®

Georgia Small Group Business (2 - 99 Eligible Employees) Employee Enrollment/Change Form

Member Aetna ID Number (if available)

Employer 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 B and H.**			
Effective Date **Date of Hire**	☐ New Hire ☐ Rehire/ Reinstatement ☐ New Group Enrollment ☐ Late Enrollment ☐ Other _____	☐ Change of coverage ☐ Add Spouse/Dependent Child ☐ Name Change ☐ Other _____	☐ Employee Termination ☐ Remove Spouse/ Dependent Child ☐ Cancel Coverage	COBRA/State Continuation for: ☐ Employee ☐ Dependent Length of Continuation: ☐ 18 ☐ 36 ☐ Other _____ Original Qualifying Event Date _____ Reason _____

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

1. Medical - Check one.

☐ **HMO Open Access – Plan:** _____

☐ **POS Open Access – Plan:** _____

☐ **MC Open Access – Plan:** _____

☐ **PPO – Plan:** _____

☐ **Indemnity – Plan:** _____

2. Dental – To enroll, enter plan number and name below.

Standard Plans:
Plan Number: _____
Plan Name: _____
If Freedom-of-Choice, check: ☐ DMO® *or* ☐ PPO

Voluntary Plans:
Plan Number: _____
Plan Name: _____
If Freedom of Choice, check: ☐ DMO® *or* ☐ PPO

Out-of-State PPO Plans:
Plan Name: _____

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

3. Life and Disability

☐ Basic Life/AD&D Ultra™
☐ Optional Dependent Life
☐ Short Term Disability
☐ Life & Disability Packaged Plan

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

Beneficiary Social Security Number

Relationship to Employee

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

Social Security Number	Last Name, First Name, M.I.		Job Title	Home Telephone	Primary Language Spoken (Optional)
Home Address		Apt. No.	City, State		ZIP Code
Work Address			City, State	ZIP Code	Work Telephone

Salary	No. of Hours Worked Per Week	Check One	Marital Status	No. of Dependents Including Spouse
$ ☐ Hourly ☐ Weekly ☐ Monthly		☐ Full-Time ☐ Part-Time	☐ Married ☐ Single	

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

(**A**)dd (**C**)hange (**R**)emove	Name (Last, First, M.I.)	Sex M/F	Social Security Number	Birthdate (MM/DD/**YYYY**)	Height (ft, in)	Weight (lbs)	Incapacitated	Coverage Election	Other Health Coverage	Other Dental Coverage	Prior Dental Coverage	Student Age 19 or Older	Primary Office ID Number (if applicable)	Current Patient	Dental Office ID Number (if applicable)	Current Patient
	Employee 1.						Yes ☐	☐ Medical ☐ Dental ☐ Life/Dis	Yes ☐	Yes ☐	Yes ☐	Yes N/A		Yes ☐		Yes ☐
	Spouse 2.						☐	☐ Medical ☐ Dental ☐ Life	☐	☐	☐	N/A		☐		☐
	Child 3.						☐	☐ Medical ☐ Dental ☐ Life	☐	☐	☐	☐		☐		☐
	Child 4.						☐	☐ Medical ☐ Dental ☐ Life	☐	☐	☐	☐		☐		☐

D. Other Insurance

Does anyone enrolling on this enrollment form have current or prior coverage? ☐ Yes ☐ No

Proof of coverage must accompany this enrollment form for pre-existing condition credit and if an employee is waiving coverage. Acceptable forms of proof are:

1. Certificate of Creditable Coverage from prior carrier, or
2. Copy of ID card or most recent payroll stub showing medical coverage deduction, or
3. Copy of most recent medical premium bill from prior carrier.

Failure to provide Proof of Prior Coverage may subject you or a family member to the full pre-existing conditions limitation with no credit for prior coverage. You may request a Certificate of Creditable Coverage from your prior carrier.

Name of Covered Individual	Carrier Name	Group Number	Start Date	Termination Date	Health	Dental
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No

E. 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	

F. Dependent Information

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

If age 19+ and a full-time student, provide the following:

Child Name	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.)

Employee 1.	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____	**Child 3.**	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____
Spouse 2.	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____	**Child 4.**	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____

H. Declination/Waiver of Coverage - *Check all that apply.*

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

☐ Employee	☐ Medical	☐ Dental	Reason for declining coverage (If applicable attach front/back of your health ID card): ☐ Covered by spouse's group coverage - Carrier Name and ID number: _____ ☐ Enrolled in other insurance - Carrier Name and ID number: _____ ☐ Spouse covered by employer's group coverage ☐ Medicare ☐ TRICARE ☐ CHAMPVA ☐ Other _____
☐ Spouse	☐ Medical	☐ Dental	
☐ Child(ren)	☐ Medical	☐ Dental	

I certify I have been given the right to apply for this coverage, however, I am waiving coverage as noted above. 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. Pre-existing conditions, when enrolled in this plan, may not be covered for twelve months.

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

I. Health Questionnaire for Groups Enrolling 2 - 9 Eligible Employees (or 2-99 if enrolling for Life above the Guaranteed Issue Amount)

Health History for Individuals and Their Dependents. ***The following information is confidential and will not be seen by or given to your employer.***

- ALL of the questions must be answered by you and your dependents or the application will be returned.
- Incomplete applications may delay the effective date of your coverage.

In the past 36 months, has any person listed on the application seen a health care provider(s), had treatment recommended, received treatment, including prescription medications or been hospitalized for any of the following conditions listed below?	**Yes**	**No**
1. Heart attack, heart murmur, stroke, chest pain, high blood pressure, anemia, varicose veins or other disorders of the heart, blood, blood vessels or high cholesterol?	☐	☐
2. Ulcer, colitis, gallstones or any other disorder of the stomach, intestines, rectum, pancreas, liver or Hepatitis B/C?	☐	☐
3. Cancer, cyst or tumor?	☐	☐
4. Disorders of the kidneys, adrenal glands, thyroid gland, urinary system, male or female organs, infertility, menstrual dysfunction or sexually transmitted disease (except AIDS/ARC)?	☐	☐
5. Asthma, emphysema, tuberculosis or any other disorders of the lungs or respiratory system?	☐	☐
6. Migraines, fainting spells, epilepsy, mental or nervous conditions, depression, paralysis or any disorder of the brain or nervous system? If epileptic, date of last seizure: ___/___/___ (month/day/year)	☐	☐
7. Lupus, arthritis, back trouble or any other disorder of the joints, muscles or bones, including prosthetic device or implants?	☐	☐
8. Any physical deformity, defect or congenital problem?	☐	☐
9. Has any person to be covered had or has been told by a physician, or diagnosed, treated, or tested positive for AIDS, or AIDS-Related Complex?	☐	☐
10. Has any person been treated for alcoholism, other drug or substance abuse, including use of any illegal or controlled drugs, or been advised to seek treatment for the same?	☐	☐
11. Has any person been diagnosed with diabetes? If Yes, list date of diagnosis: ___/___/___ (month/day/year) ☐ Insulin dependent ☐ Non-insulin dependent	☐	☐
12. a. Is any female to be covered currently pregnant? If Yes, list due date: ___/___/___ (month/day/year)	☐	☐
b. Have there been any complications thus far?	☐	☐
c. Are multiple births expected?	☐	☐
d. If you are a male listed on this application, are you expecting a child with anyone, even if the mother is not listed on this application?	☐	☐
13. Has any applicant taken any prescribed medications in the past 12 months? **If Yes, list on next page.**	☐	☐

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS ABOVE YOU MUST COMPLETE SECTION K ON THE FOLLOWING PAGE.

Continued next page

I. Health Questionnaire for Groups Enrolling 2 - 9 Employees (Continued)

	Yes	No
14. Has any applicant had an abnormal physical exam or been advised to undergo further testing, surgery or treatment?	☐	☐
15. Has any applicant been a patient in a hospital, clinic, surgical center, sanatorium or medical facility as an outpatient or inpatient (excluding childbirth)?	☐	☐
16. Do you or your spouse use tobacco products, including cigarettes, pipe, cigars, or chewing tobacco?	☐	☐
If Yes, check applicable boxes: ☐ Employee ☐ Spouse		
17. Has any applicant had any medical condition or symptom not listed on this application?	☐	☐

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS ABOVE YOU MUST COMPLETE SECTION K BELOW.

J. For Groups Enrolling 10 - 99 Eligible Employees

	Yes	No
1. Within the last 24 months has anyone applying for coverage consulted, received treatment, had prescription medication prescribed by a doctor, psychiatrist, psychologist, or other practitioner or been diagnosed with: heart, circulatory or vascular disease, stroke/brain/ neurological/central nervous system, kidney/bladder, digestive, stomach, intestinal, liver or pancreatic disorder, muscular or systemic disease (including, but not limited to arthritis or lupus), mental/nervous/emotional/eating disorder/condition, Endocrine disorder, Epilepsy/ seizures, diabetes, lung or respiratory disorder, cancer, blood disorder, Hemophilia, bone/joint/muscle/paralysis disorder, prosthetic device, alcohol or drug use, infertility, transplant (recommended, pending or complete), Pituitary/Adrenal/growth disorder, enlarged lymph nodes, Kawasaki disease, IgA Deficiencies, Polymyositis, Sjoren's Syndrome, Scleroderma, Mysathenia Gravis, Hasimoto's thyroiditis, Systemic Lupus Erythematosus, Cystic Fibrosis, or had positive diagnosis for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC), are currently pregnant, or surgery or treatment is needed or pending, or had medical claims in excess of $15,000?	☐	☐
2. Do you or your spouse use tobacco products, including cigarettes, pipe, cigars, or chewing tobacco?	☐	☐
If Yes, check applicable boxes: ☐ Employee ☐ Spouse		

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS ABOVE YOU MUST COMPLETE SECTION K BELOW.

If you are providing additional sheets, check here ☐ and insert the sheets before sealing this Enrollment form.

K. Health Questionnaire - Details for "Yes" Responses in Sections I and J.

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS IN SECTIONS I AND J, YOU MUST COMPLETE THE FOLLOWING.

Please provide us with FULL DETAILS for each "Yes" answer to any condition(s) checked in Sections I and J. **In addition**, please give details below of last doctor visit and/or physical examination for **ALL** family members listed regardless of the date or reason. *(Insert additional sheets if necessary.)*

Question Number	Name of Individual	Condition/Diagnosis	Date of Onset	Date Treatment Ended	Medication Prescribed	Dosage	Still Taking Medication
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

If you are providing additional sheets, check here ☐ and insert the sheets before sealing this Enrollment form.

Disclosure Acknowledgment

I understand that I am enrolling in a health care plan issued by Aetna Health Inc. or Aetna Life Insurance Company ("Aetna") that requires health care services be provided by participating providers. Failure to use a participating provider will result in reduced coverage or no coverage for services that I receive, and I will be fully responsible for any and all costs not covered by Aetna.

I received a list of participating providers. I may verify the participation status of a provider by using DocFind® at Aetna's web site, http://www.aetna.com. DocFind is updated weekly and can also be used to select a provider based on name, geographic location, group practice, medical specialty and/or hospital affiliation. I may also verify provider status by contacting Member Services at the number listed on my member ID card. I understand that the participation status of any provider may change from time to time and that it is my responsibility to verify participation of my health care provider with Aetna prior to receiving services.

As required by the State of Georgia regulations, the following is a summary of the financial arrangements with health care providers who are participating in the Aetna Health Inc. network:

1. Hospital providers are paid according to a contract that includes inpatient per diems, case rates, and discounted fee for service arrangements depending on the specific services provided.

Continued on next page

Disclosure Acknowledgment *(Continued)*

2. Physicians are paid either a discounted fee for service in accordance with a specific fee schedule or a predetermined set amount per member per month (capitation).
3. Laboratory services are provided through a capitation arrangement (a per member per month flat fee).
4. Other ancillary services including home health, skilled nursing, and hospice are paid on a contracted fee schedule with per diems or per visit amounts, or through a capitated per member per month flat fee.

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 in-network portion of Aetna POS plans: Aetna Health Inc.
   - Out-of-network portion of Aetna POS plans: Aetna Health Insurance Company
   - Aetna PPO plans: Aetna Life Insurance Company
   - Life, Accidental Death & Dismemberment, 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 application will determine coverage and that there is no coverage unless and until both this enrollment form and the employer application have been accepted by Aetna. Even if this enrollment form is accepted, any intentional and material misstatements or omissions may result in future claims being denied and 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.
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 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 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 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 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. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any person who knowingly and with intent to defraud any insurance company or other person files an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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 **Georgia** Small Group Business (2-99 Eligible Employees) Employee Enrollment/Change Form. I understand that, in the event I fail to sign 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 25 hours per week for this employer at the regular place of business.

I have read and understand the information provided in the Disclosure section of this form.

Employee Signature	*Spouse Signature (Optional - required only if enrolling)*	*Employee E-mail Address (optional)*	*Date (Month/Day/Year)*
X	**X**		