

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 through 4 are not visible.



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

Group Number
Member Aetna ID Number (if available)

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	<input type="checkbox"/> New Hire <input type="checkbox"/> Waiver <input type="checkbox"/> Rehire/Reinstatement <input type="checkbox"/> Other	<input type="checkbox"/> Change of coverage <input type="checkbox"/> Add Spouse/ Dependent Child	<input type="checkbox"/> Employee Termination <input type="checkbox"/> Remove Spouse/ Dependent Child	COBRA for: <input type="checkbox"/> Employee <input type="checkbox"/> Dependent Length of Continuation: <input type="checkbox"/> 18 <input type="checkbox"/> 36 <input type="checkbox"/> Other _____	
Date of Hire	<input type="checkbox"/> New Group Enrollment <input type="checkbox"/> Late Enrollment <input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Name Change <input type="checkbox"/> Other _____	<input type="checkbox"/> Cancel Coverage Original Qualifying Event Date _____		Qualifying Event _____

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

Last Name, First Name, M.I.	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	Job Title	Home Telephone	Primary Language Spoken (Optional)
Home Address	Apt. No.	City, State		ZIP Code
Work Address	City, State		ZIP Code	Work Telephone

B. Coverage Selection - Please print clearly, using black ink. (Top boxes 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 - <input type="checkbox"/> Yes <input type="checkbox"/> No <i>To enroll, enter plan option elected next to the plan type below:</i> <input type="checkbox"/> PA POS - Plan Option: _____ <input type="checkbox"/> PA POS No Referral - Plan Option: _____ <input type="checkbox"/> PA POS Cost-Sharing - Plan Option: _____ <input type="checkbox"/> PA POS Cost-Sharing No Referral Plan Option: _____ <input type="checkbox"/> PA POS Consumer-Directed No Referral Plan Option: _____ <input type="checkbox"/> PA POS HSA Compatible No Referral Plan Option: _____ <input type="checkbox"/> PA PPO - Plan Option: _____ <input type="checkbox"/> PA PPO Cost-Sharing - Plan Option: _____ <input type="checkbox"/> PA PPO HSA Compatible - Plan Option: _____ <input type="checkbox"/> PA Health Network Option AHF HRA - Plan Option: _____ <input type="checkbox"/> PA Indemnity - Plan Option: _____ <input type="checkbox"/> Other Plan - Plan Option _____					2. Dental - <input type="checkbox"/> Yes <input type="checkbox"/> No <i>To enroll, enter plan number and name elected below.</i> Contributory Plan: Plan Number: _____ Plan Name: _____ If Freedom-of-Choice, check: <input type="checkbox"/> DMO® or <input type="checkbox"/> PPO Voluntary Plans: Plan Number: _____ Plan Name: _____ If Freedom of Choice, check: <input type="checkbox"/> DMO® or <input type="checkbox"/> PPO Out-of-State PPO Plans: Plan Name: _____ Before today, were you covered under this employer's dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No					3. Life and Disability - For Dependent Life, dependents are eligible from 14 days of age up to their 19 th birthday, or up to their 23 rd birthday, if a full-time student. <input type="checkbox"/> Basic Life/AD&D Ultra™ <input type="checkbox"/> Optional Dependent Life <input type="checkbox"/> Life & Disability Packaged Plan		
Beneficiary Designation - Full Name (First, Middle, Last) _____												
Beneficiary Social Security Number _____												
Relationship to Employee _____												

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

1. Employee Name (Last, First, M.I.)						Sex (M/F)	Social Security Number			
Birthdate (MM/DD/YYYY)	Height (ft, in)	Weight (lbs)	Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life/Disability	PCP Provider ID Number		Dental Office ID Number		Current Patient Yes <input type="checkbox"/>		
2. Spouse Name (Last, First, M.I.)						Sex (M/F)	Social Security Number		Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____	
Birthdate (MM/DD/YYYY)	Height (ft, in)	Weight (lbs)	Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	PCP Provider ID Number		Dental Office ID Number		Current Patient Yes <input type="checkbox"/>		
3. Child Name (Last, First, M.I.)						Sex (M/F)	Social Security Number		Relationship <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____	
Birthdate (MM/DD/YYYY)	Height (ft, in)	Weight (lbs)	Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	PCP Provider ID Number		Dental Office ID Number		Current Patient Yes <input type="checkbox"/>		
4. Child Name (Last, First, M.I.)						Sex (M/F)	Social Security Number		Relationship <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____	
Birthdate (MM/DD/YYYY)	Height (ft, in)	Weight (lbs)	Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	PCP Provider ID Number		Dental Office ID Number		Current Patient Yes <input type="checkbox"/>		

J. Health Questionnaire – Details for “Yes” Responses in Section I.

List all individuals enrolling for coverage.	Height	Weight	Smoker	Currently Taking Prescription Medication(s)
Name			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

K. Provide details below to any boxes checked above. (If additional space is needed, attach a separate sheet and be sure to sign and date the sheet.)

Ques. No.	Name of Individual	Condition/Diagnosis/Treatment	Date of Onset	Date Treatment Ended	Names of Prescription Medication(s)	Dosage	Still Taking Medication
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
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							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No

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

Conditions of Enrollment

On behalf of myself and the dependents listed on Page 1, 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 plans and Aetna POS plans: Aetna Health Inc. and/or Aetna Health Insurance Company
 - Aetna PPO plans: Aetna Life Insurance Company
 - Life, Accidental Death & Dismemberment, disability, dental and all other 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 the 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, or which would have affected the carrier's rating, offering or issuing of coverage impacted, 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. Failure to disclose all health information encompassed by the questionnaire will be deemed to be material omissions for 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 and 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.
7. I understand and agree that, as described in the plan documents and when enrolled for medical coverage, any pre-existing conditions for my spouse, dependents or myself may not be covered for 12 months. NOTE: If your Plan contains a pre-existing conditions provision, the pre-existing conditions exclusion and limitation will not apply to a person under 19 years of age.

Misrepresentation

8. 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 to the best of my knowledge and belief. I have read and agree to the Conditions of Enrollment and Misrepresentation on this **Pennsylvania** 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 full time at least 25 hours per week for this employer at the regular place of business.

<i>Employee Signature (Required to enroll)</i>	<i>Employee E-mail Address (optional)</i>	<i>Date (Month/Day/Year)Required</i>
X		
<i>Employer Signature</i>		<i>Date (Month/Day/Year)</i>
X		