Connecticut Small Group Business (1 - 50 Eligible Employees*) Employee Enrollment/Change Form

* Life Insurance available only to groups of 2 to 50 eligible employees.

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 E.**

Effective Date

Date of Hire

- ☐ New Hire
- ☐ Rehire/Reinstatement
- ☐ New Group Enrollment
- ☐ Late Enrollment
- ☐ Other _____

- ☐ Change of coverage
- ☐ Add Spouse/Civil Union Partner/ Domestic Partner/Dependent Child
- ☐ Name Change
- ☐ Other _____

- ☐ Employee Termination
- ☐ Remove Spouse/Civil Union Partner/Domestic Partner/ 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.

- ☐ Aetna Open Access® QPOS
  Plan Option: _____
- ☐ Aetna Open Access® Managed Choice
  Plan Option: _____
- ☐ Aetna Traditional Choice®
  Plan Option: _____
- ☐ Mandated CSEHRP HMO
- ☐ Mandated CSEHRP Traditional Choice
- ☐ Other Plan Option: _____

2. Dental - Check one.

Standard Plans
Option: _____
Options 2 & 4: DMO® ☐ *or* PPO ☐

Voluntary Plans
Option: _____
Option 2: DMO® ☐ *or* PPO ☐

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.		Home Telephone	Primary Language Spoken (Optional)
Home Address	Apt. No.	City, State		ZIP Code
Work Address	City, State		ZIP Code	Work Telephone

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

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

NOTE FOR MEDICAL AND DENTAL COVERAGE: While the Federal Patient Protection and Affordable Care Act mandates coverage of dependent children up to age 26 for medical plans and some dental plans, your plan may allow coverage beyond age 26. Some exceptions apply. Please refer to your plan documents or contact your benefits administrator.

Name (Last, First, M.I.)	Sex M/F	Social Security Number	Birthdate (MM/DD/YYYY)	Height (ft, in)	Weight (lbs)	Coverage Election	Other Health Coverage	Other Dental Coverage	Prior Dental Coverage	Student (Life Only)	Out of Area	Primary Office ID Number (if applicable)	Current Patient	Dental Office ID Number (if applicable)	Current Patient
Employee 1.						☐ Medical ☐ Dental ☐ Life/Dis	Yes ☐	Yes ☐	Yes ☐	Yes N/A	Yes ☐		Yes ☐		Yes ☐
Spouse /Civil Union Partner/Domestic Partner 2.						☐ Medical ☐ Dental ☐ Life	☐	☐	☐	N/A	☐		☐		☐
Child 3.						☐ Medical ☐ Dental ☐ Life	☐	☐	☐	☐	☐		☐		☐
Child 4.						☐ Medical ☐ Dental ☐ Life	☐	☐	☐	☐	☐		☐		☐

D. 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 Latin – 03 ☐ Asian – 04 ☐ Other – 05 _____	**Child 3.**	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latin – 03 ☐ Asian – 04 ☐ Other – 05 _____
Spouse/Civil Union Partner/Domestic Partner 2.	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latin – 03 ☐ Asian – 04 ☐ Other – 05 _____	**Child 4.**	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latin – 03 ☐ Asian – 04 ☐ Other – 05 _____

E. 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.

☐ Waive Medical coverage for:	☐ Myself	☐ Spouse	☐ Child(ren)	**Reason for declining coverage** *(If applicable attach front/back of your health ID card.)*
☐ Waive Dental coverage for:	☐ Myself	☐ Spouse	☐ Child(ren)	☐ Spousal group coverage ☐ COBRA coverage
☐ Waive Life coverage for:	☐ Myself	☐ Spouse	☐ Child(ren)	☐ Medicare ☐ Military coverage
☐ Waive Disability coverage for:	☐ Myself			☐ Medicaid ☐ Another group plan provided by my employer
				☐ Individual coverage ☐ Do not want
				☐ Retiree coverage ☐ Other: _____

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 I 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 other than an HMO plan, may not be covered for twelve months. **NOTE:** If your Plan contains a pre-existing conditions provision, the preexisting conditions exclusion and limitation will not apply to a person under 19 years of age.

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

F. Dependent Information

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

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

Child Name	School Name	Expected Graduation Date	Number of Credit Hours

G. Other Insurance

Does anyone age 19 or over enrolling on this enrollment form have prior medical coverage? ☐ Yes ☐ No If Yes, provide the information requested in the table below. Proof of coverage should accompany this enrollment form for pre-existing condition credit if enrolling in other than an HMO plan. **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.

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

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: Aetna Health Inc.
   - Aetna POS plans and in-network portion of the QPOS plans: Aetna Health Inc. and/or Aetna Life Insurance Company.
   - Out-of-network portion of the QPOS plans, Indemnity, PPO plans, Life, Accidental Death & Dismemberment, DMO®, and Dental PPO plans: 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 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 begin rescinded or 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.

continued on next page

Conditions of Enrollment *(continued)*

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"), to give to Aetna or its agent information concerning the medical 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/civil union partner/ domestic partner 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 for 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. In Connecticut, DMO plans provide out-of-network benefits. However, in order to receive maximum benefits, members must select and have care coordinated by a participating primary care dentist. Connecticut DMO is not an HMO.

Misrepresentation

7. Any person who knowingly and with intent to defraud any insurance company or other person files an application 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 **Connecticut** Small Group Business (1 - 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 30 hours per week for this employer at the regular place of business.

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