***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 the health information pages are not visible.***

aetna®

# New York Small Group Business (1 – 50 Eligible Employees) Employee Enrollment/Change Form for Life, AD&PL, Medical and Dental Coverage

Life, Accidental Death & Personal Loss, DMO® and PPO dental plans, Aetna EPO plans, Aetna Indemnity, Aetna Managed Choice Plan PPO, and Aetna NYC Community Plan℠ are provided by Aetna Life Insurance Company.

## Aetna Life Insurance Company

151 Farmington Avenue
Hartford, CT 06156
(888) 802-3862

**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.**

Member Aetna ID Number (if available)

**Employer Name**

| **Effective Date** / **Date of Hire** | | | | |
|---|---|---|---|---|
| | ☐ New Hire<br>☐ Rehire/Reinstatement<br>☐ New Group Enrollment<br>☐ Late Enrollment<br>☐ Other _____ | ☐ Change of Coverage<br>☐ Add Spouse/Domestic Partner/Dependent Child<br>☐ Name Change<br>☐ Other _____ | ☐ Employee Termination<br>☐ Remove Spouse/ Domestic Partner/ Dependent Child<br>☐ Cancel Coverage | COBRA/State Continuation for:<br>☐ Employee ☐ Dependent<br>Length of Continuation:<br>☐ 18 ☐ 36 ☐ Other _____<br>Original Qualifying Event Date _____<br>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 |
|---|---|---|---|---|
| | | | | |

**1. Medical**

☐ Open Access Elect Choice® (OAEPO) Plan Option: _____
☐ Open Access Managed Choice® (OAMC) Plan Option: _____
☐ Open Access Elect Choice® (OAEPO) HSA Compatible Plan Option: _____
☐ Open Access Managed Choice® (OAMC) HSA Compatible Plan Option: _____
☐ NYC Community Plan℠ Plan Option: _____
☐ Indemnity Plan Option: _____

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

**2. Dental**

**Standard Plans:** Option: _____ FOC: ☐ DMO® *or* ☐ PPO
**Voluntary Plans:** Option: _____ FOC: ☐ DMO® *or* ☐ PPO

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

**A.** Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a New York Health Benefit Exchange-certified stand-alone dental plan offered outside the New York Health Benefit Exchange? ☐ Yes ☐ No

**B.** If you answered "Yes," please provide the name of the company issuing the stand-alone dental coverage: _____
If you answered "No," we will provide you coverage of the pediatric dental essential health benefit.

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

**3. Life and Disability** ☐ Basic Life/AD&D Ultra® ☐ Optional Dependent Life ☐ Life & Disability Packaged Plan

| **Full Beneficiary Name** (First, Middle, Last) | Beneficiary Social Security Number | Birthdate (MM/DD/YYYY) / / |
|---|---|---|
| | | |

| Beneficiary Address (Number, Street, **Apt. No.**, City, State, ZIP Code) | Telephone Number ( ) - | Relationship to Employee |
|---|---|---|
| | | |

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

| Last Name, First Name, M.I. | | | Job Title |
|---|---|---|---|
| | | | |
| **Home Address** | **Apt. No.** | **City, State** | **ZIP Code** |
| | | | |
| **Work Address** | | **City, State** | **ZIP Code** |
| | | | |
| **Home Telephone** ( ) - | **Work Telephone** ( ) - | **Primary Language Spoken (Optional)** | **No. of Hours Worked Per Week** |
| | | | |
| **Number of Dependents (including Spouse/ Civil Union/ Domestic Partner) enrolling for coverage** | **Check One** ☐ Full-Time ☐ Part-Time ☐ 1099 ☐ Retired ☐ Seasonal ☐ Temporary ☐ Union ☐ COBRA | | **Marital Status** ☐ Single ☐ Married |
| | | | |

**C. Individuals Covered -** ***List individuals for whom you are enrolling or adding/changing/removing coverage. Insert 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, your plan may allow coverage beyond age 26 for medical plans and some dental plans. Some exceptions apply. Please refer to your plan documents or contact your benefits administrator.

| 1 | **Employee Name** (Last, First, M.I.) | | | | Sex (M/F) | **Social Security Number** | | **Birthdate** (MM/DD/**YYYY**) / / |
|---|---|---|---|---|---|---|---|---|
| Coverage Election ☐ Medical ☐ Dental ☐ Life/Dis | Other Health Coverage **Yes** ☐ | Other Dental Coverage **Yes** ☐ | Prior Dental Coverage **Yes** ☐ | Out of Area **N/A** | Student (Life Only) **N/A** | Dental Office ID Number *(if applicable)* | | Current Patient **Yes** ☐ |
| Primary Office ID Number *(if applicable)* | Physician First & Last Name | | | | | Provider ID Number (*if applicable*) | | Current Patient **Yes** ☐ |

| 2 | **Spouse/Domestic Partner** (Last, First, M.I.) | | | | Sex (M/F) | **Social Security Number** | | **Birthdate** (MM/DD/**YYYY**) / / |
|---|---|---|---|---|---|---|---|---|
| Coverage Election ☐ Medical ☐ Dental ☐ Life | Other Health Coverage **Yes** ☐ | Other Dental Coverage **Yes** ☐ | Prior Dental Coverage **Yes** ☐ | Out of Area **N/A** | Student (Life Only) **N/A** | Dental Office ID Number *(if applicable)* | | Current Patient **Yes** ☐ |
| Primary Office ID Number *(if applicable)* | Physician First & Last Name | | | | | Provider ID Number (*if applicable*) | | Current Patient **Yes** ☐ |

| 3 | **Child** (Last, First, M.I.) | | | | Sex (M/F) | **Social Security Number** | | **Birthdate** (MM/DD/**YYYY**) / / |
|---|---|---|---|---|---|---|---|---|
| Coverage Election ☐ Medical ☐ Dental ☐ Life | Other Health Coverage **Yes** ☐ | Other Dental Coverage **Yes** ☐ | Prior Dental Coverage **Yes** ☐ | Out of Area **Yes** ☐ | Student (Life Only) **Yes** ☐ | Dental Office ID Number *(if applicable)* | | Current Patient **Yes** ☐ |
| Primary Office ID Number *(if applicable)* | Physician First & Last Name | | | | | Provider ID Number (*if applicable*) | | Current Patient **Yes** ☐ |

| 4 | **Child** (Last, First, M.I.) | | | | Sex (M/F) | **Social Security Number** | | **Birthdate** (MM/DD/**YYYY**) / / |
|---|---|---|---|---|---|---|---|---|
| Coverage Election ☐ Medical ☐ Dental ☐ Life | Other Health Coverage **Yes** ☐ | Other Dental Coverage **Yes** ☐ | Prior Dental Coverage **Yes** ☐ | Out of Area **Yes** ☐ | Student (Life Only) **Yes** ☐ | Dental Office ID Number *(if applicable)* | | Current Patient **Yes** ☐ |
| Primary Office ID Number *(if applicable)* | Physician First & Last Name | | | | | Provider ID Number (*if applicable*) | | Current Patient **Yes** ☐ |

| 5 | **Child** (Last, First, M.I.) | | | | Sex (M/F) | **Social Security Number** | | **Birthdate** (MM/DD/**YYYY**) / / |
|---|---|---|---|---|---|---|---|---|
| Coverage Election ☐ Medical ☐ Dental ☐ Life | Other Health Coverage **Yes** ☐ | Other Dental Coverage **Yes** ☐ | Prior Dental Coverage **Yes** ☐ | Out of Area **Yes** ☐ | Student (Life Only) **Yes** ☐ | Dental Office ID Number *(if applicable)* | | Current Patient **Yes** ☐ |
| Primary Office ID Number *(if applicable)* | Physician First & Last Name | | | | | Provider ID Number (*if applicable*) | | Current Patient **Yes** ☐ |

| 6 | **Child** (Last, First, M.I.) | | | | Sex (M/F) | **Social Security Number** | | **Birthdate** (MM/DD/**YYYY**) / / |
|---|---|---|---|---|---|---|---|---|
| Coverage Election ☐ Medical ☐ Dental ☐ Life | Other Health Coverage **Yes** ☐ | Other Dental Coverage **Yes** ☐ | Prior Dental Coverage **Yes** ☐ | Out of Area **Yes** ☐ | Student (Life Only) **Yes** ☐ | Dental Office ID Number *(if applicable)* | | Current Patient **Yes** ☐ |
| Primary Office ID Number *(if applicable)* | Physician First & Last Name | | | | | Provider ID Number (*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. 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.*

**1. Medical Coverage Declined for:**
- ☐ Myself
- ☐ Spouse/Domestic Partner:
- ☐ Children

**2. Dental Coverage Declined for:**
- ☐ Myself
- ☐ Spouse/Domestic Partner:
- ☐ Children

**Reason for declining coverage**
- ☐ Spousal/Domestic Partner group coverage
- ☐ Parental Coverage
- ☐ Medicare
- ☐ Medicaid
- ☐ Retiree coverage
- ☐ Another group plan provided by my employer
- ☐ COBRA coverage
- ☐ Individual coverage - On or Off Exchange
- ☐ Insurance through another job
- ☐ TRICARE Military coverage
- ☐ VA Coverage
- ☐ 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).* | *Date (Month/Day/Year)* |
|---|---|
| **Employee Signature X** | |

## F. 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 |
|---|---|---|---|
| | | | |
| | | | |

*continued on next page*

**Conditions of Enrollment**

On behalf of myself and the dependents listed on Page 2, I agree to or with the following:

1. I acknowledge that by enrolling in an Aetna plan(s) on Page 1, coverage is provided by Aetna Life Insurance Company (referred to as "Aetna").
2. I understand that: my employer's application will determine coverage and that there is no coverage unless and until both the eligible employee enrollment form and employer application have been accepted and approved by Aetna.
   ***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. 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. Life insurance is incontestable after two years from date of issue, except for non-payment of premiums. 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 form may be transmitted to Aetna or its agent by my employer or its agent.
4. The plan certificate of coverage will determine the rights and responsibilities of member(s). It 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, 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 dentist or by the participating dentist or other provider as authorized by a referral from a participating primary care dentist.
7. This form is attached to and forms part of the policy and certificate, and may be used to contest the insurance.
8. The validity of individual coverage may be contested within the first two years during the insured's lifetime using written, signed statements made by the insured relating to their insurability with respect to which such statement was made only if a copy has been furnished to the insured or their beneficiary. The policy is incontestable after two years other than non-payment of premiums.

**Misrepresentation (This fraud warning is not applicable to an application for life insurance.)**

9. 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I represent that to the best of my knowledge and belief all information supplied in this form is true and complete. I have read and agree to the Conditions of Enrollment and Misrepresentation on this **New York** Small Group Business (1 – 50 Eligible Employees) Employee Enrollment/Change Form. I understand that if I do not sign this form within 31 days from the date first eligible or 31 days of the qualifying life event (i.e., marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.) I will be considered a late enrollee and the effective date of coverage for me and my dependents may be affected. I am employed by the employer shown on Page 1, and I am working full time at least 20 hours per week for this employer at the regular place of business.

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

***This form is attached to and made a part of the group policy.***