

**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.**



# Pennsylvania Employee Enrollment/Change Form (50 or fewer employees)

Group Number
Member Aetna ID Number (if available)

**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 B.**

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

**A. 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
Salary \$	<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	Check One <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> 1099 <input type="checkbox"/> Retired <input type="checkbox"/> Seasonal <input type="checkbox"/> Temporary <input type="checkbox"/> Union <input type="checkbox"/> COBRA	

**B. Waiver of Coverage - To be completed if coverage is declined or refused by an eligible employee and/or their eligible family members.**

I understand I am eligible to apply for this coverage through my employer; however, I am waiving coverage as noted below.	
<b>Employee:</b> <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life <input type="checkbox"/> Vision <input type="checkbox"/> Disability	<b>Reason for Declining Coverage</b> <input type="checkbox"/> Spouse/Domestic Partner group coverage <input type="checkbox"/> Another group plan provided by my employer <input type="checkbox"/> Parental group coverage <input type="checkbox"/> Insurance through another job <input type="checkbox"/> COBRA coverage <input type="checkbox"/> Individual coverage - On or Off Exchange <input type="checkbox"/> Medicare <input type="checkbox"/> TRICARE Military coverage <input type="checkbox"/> Medicaid <input type="checkbox"/> Do not want <input type="checkbox"/> Retiree coverage <input type="checkbox"/> Other _____
<b>Spouse:</b> <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life <input type="checkbox"/> Vision	
<b>Child(ren):</b> <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life <input type="checkbox"/> Vision	
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 <b>ONLY</b> if you are declining coverage for yourself or your dependent(s).	Date (Month/Day/Year)
<b>X</b> Employee Signature	

**C. Coverage Selection – Please print clearly, using black ink. (Top boxes for Employer/Aetna-Use Only.)**

Control/Group No.	Suffix	Account	Plan No.	Class Code
<b>1. Medical</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>To enroll, check one and enter the plan option elected following the plan type below.</i> <input type="checkbox"/> PA HMO – Plan Option: _____ <input type="checkbox"/> PA HMO HSA Compatible – Plan Option: _____ <input type="checkbox"/> PA HMO Savings Plus – Plan Option: _____ <input type="checkbox"/> PA QPOS – Plan Option: _____ <input type="checkbox"/> PA Health Network Option – Plan Option: _____ <input type="checkbox"/> PA Health Network Option HSA Compatible – Plan Option: _____ <input type="checkbox"/> PA PPO – Plan Option: _____ <input type="checkbox"/> PA PPO HSA Compatible – Plan Option: _____ <input type="checkbox"/> PA AWH PPO – Plan Option: _____ <input type="checkbox"/> PA AWH PPO HSA Compatible – Plan Option: _____ <input type="checkbox"/> PA Indemnity – Plan Option: _____ <input type="checkbox"/> Other Plan – Plan Option: _____				

Control/Group No.	Suffix	Account	Plan No.	
<b>2. Dental</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>To enroll, enter the plan number and name elected below.</i> <b>Contributory Plans:</b> Plan Number _____ Plan Name: _____ If FOC, choose: <input type="checkbox"/> DMO® or <input type="checkbox"/> PPO <b>Voluntary Plans:</b> Plan Number _____ Plan Name: _____ If FOC, choose: <input type="checkbox"/> DMO® or <input type="checkbox"/> PPO <b>Before today, were you covered under this employer's dental plan?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No				

Control/Group No.	Suffix	Account	Plan No.	
<b>3. Life and Disability</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Check applicable boxes.</i> <input type="checkbox"/> Basic Life/AD&D Ultra® <input type="checkbox"/> Optional Dependent Life <input type="checkbox"/> 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

Control/Group No.	Suffix	Account	Plan No.	
<b>4. Vision</b> Aetna Vision Preferred <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Check applicable boxes.</i>				

**D. Individuals Covered - List individuals for whom you are enrolling or adding/changing/removing coverage. Insert additional sheets if necessary and staple to the back of this application. NOTE FOR MEDICAL, DENTAL AND VISION 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 and vision plans. Some exceptions apply. Please refer to your plan documents or contact your benefits administrator. **If any person has used tobacco products (cigarettes, pipe, cigars, snuff, or chewing tobacco) an average of four or more times per week within the past six months, ✓ check below. Religious or ceremonial uses of tobacco (for example, by American Indians and Alaska Natives) are exempt. This only applies to enrolling person(s) that meet or exceed the state-defined legal tobacco age.**

<b>1</b>	(A)dd (C)hange (R)emove	Employee Name (Last, First, M.I.)	Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /
Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life/Disability <input type="checkbox"/> Vision		If choosing HMO, Primary Office ID #	Current Patient Yes <input type="checkbox"/>	If choosing DMO, Primary Office ID #	Current Patient Yes <input type="checkbox"/>
Tobacco Use <input type="checkbox"/> Yes <input type="checkbox"/> No		Currently participating in Quit Smoking Program <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>2</b>	(A)dd (C)hange (R)emove	Name (Last, First, M.I.) <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /
Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life <input type="checkbox"/> Vision		If choosing HMO, Primary Office ID #	Current Patient Yes <input type="checkbox"/>	If choosing DMO, Primary Office ID #	Current Patient Yes <input type="checkbox"/>
Tobacco Use <input type="checkbox"/> Yes <input type="checkbox"/> No		Currently participating in Quit Smoking Program <input type="checkbox"/> Yes <input type="checkbox"/> No			

*continued on next page*

**D. Individuals Covered** (continued)

3	(A)dd (C)hange (R)emove	Name (Last, First, M.I.)	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /
	Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life <input type="checkbox"/> Vision		If choosing HMO, Primary Office ID #	Current Patient Yes <input type="checkbox"/>	If choosing DMO, Primary Office ID #	Current Patient Yes <input type="checkbox"/>
	Tobacco Use <input type="checkbox"/> Yes <input type="checkbox"/> No	Currently participating in Quit Smoking Program <input type="checkbox"/> Yes <input type="checkbox"/> No	Incapacitated <input type="checkbox"/> Yes <input type="checkbox"/> No			
4	(A)dd (C)hange (R)emove	Name (Last, First, M.I.)	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /
	Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life <input type="checkbox"/> Vision		If choosing HMO, Primary Office ID #	Current Patient Yes <input type="checkbox"/>	If choosing DMO, Primary Office ID #	Current Patient Yes <input type="checkbox"/>
	Tobacco Use <input type="checkbox"/> Yes <input type="checkbox"/> No	Currently participating in Quit Smoking Program <input type="checkbox"/> Yes <input type="checkbox"/> No	Incapacitated <input type="checkbox"/> Yes <input type="checkbox"/> No			
5	(A)dd (C)hange (R)emove	Name (Last, First, M.I.)	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /
	Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life <input type="checkbox"/> Vision		If choosing HMO, Primary Office ID #	Current Patient Yes <input type="checkbox"/>	If choosing DMO, Primary Office ID #	Current Patient Yes <input type="checkbox"/>
	Tobacco Use <input type="checkbox"/> Yes <input type="checkbox"/> No	Currently participating in Quit Smoking Program <input type="checkbox"/> Yes <input type="checkbox"/> No	Incapacitated <input type="checkbox"/> Yes <input type="checkbox"/> No			
6	(A)dd (C)hange (R)emove	Name (Last, First, M.I.)	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /
	Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life <input type="checkbox"/> Vision		If choosing HMO, Primary Office ID #	Current Patient Yes <input type="checkbox"/>	If choosing DMO, Primary Office ID #	Current Patient Yes <input type="checkbox"/>
	Tobacco Use <input type="checkbox"/> Yes <input type="checkbox"/> No	Currently participating in Quit Smoking Program <input type="checkbox"/> Yes <input type="checkbox"/> No	Incapacitated <input type="checkbox"/> Yes <input type="checkbox"/> No			

**E. Dependent Information**

List any dependent in Section D living at another address.

Name	Address

**For Dependent Life Only – Student Status:** If age 19 and over and a full-time student, provide the following:

Child Name	School Name	Expected Graduation Date	Number of Credit Hours

**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

**G. Case Management (OPTIONAL – This information will be used to help coordinate your care. It will not impact your premium rate or eligibility for coverage.)**

<input type="checkbox"/> AIDS	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> ALS (Amyotrophic lateral sclerosis) - Lou Gehrig's disease	<input type="checkbox"/> COPD using oxygen	<input type="checkbox"/> Muscular Dystrophy
<input type="checkbox"/> Auto Immune Disorders (e.g., scleroderma, Systemic Lupus)	<input type="checkbox"/> Cor Pulmonale	<input type="checkbox"/> Myasthenia Gravis
<input type="checkbox"/> Traumatic Brain Injury	<input type="checkbox"/> Defibrillator /AICD/ Implantable Cardioverter	<input type="checkbox"/> Paralysis
<input type="checkbox"/> Cerebral Palsy using wheelchair	<input type="checkbox"/> End of Life/Hospice	<input type="checkbox"/> Paraplegic
<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Hypertensive Heart Disease	<input type="checkbox"/> Pregnant - high risk or multiple births
	<input type="checkbox"/> Hypertensive Renal Disease	<input type="checkbox"/> Quadriplegic
Name of Individual	Condition(s)	

**Conditions of Enrollment**

On behalf of myself and the dependents listed on Pages 2 and 3, 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 Network plans and Aetna POS plans: Aetna Health Inc. and/or Aetna Health Insurance Company
  - Aetna PPO and Indemnity plans: Aetna Life Insurance Company
  - Aetna Vision<sup>SM</sup> Preferred plans: Aetna Life Insurance Company; certain claims adjudication and other administrative services are provided by First American Administrators, Inc. (an affiliate of EyeMed Vision Care, LLC) and/or its affiliates;
  - Life, Accidental Death & Personal Loss, 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.  
**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 19<sup>th</sup> birthday, or up to their 23<sup>rd</sup> 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/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 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<sup>®</sup>, 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<sup>®</sup> 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. 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 to the best of my knowledge and belief. I have read and agree to the Conditions of Enrollment and Misrepresentation on this **Pennsylvania** 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 eligibility 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 authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments as required for coverage.

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