Enrollment/Change Request
Aetna Health Inc.

Control	Suffix	Account	Plan Number
Group Number			Class Code

Employer Group Information (To Be Completed by Employer) — Group Name / Employer Name - Full Name of Business or Organization

A. Type of Activity - Employee Completes Sections A - E. *Please Print Clearly.*

Instructions: *Refer to the instructions on the back before completing this form. You must complete this application in full or it will be returned to you resulting in a delay in processing. You are solely responsible for its accuracy and completeness.*

Enrollment
- ☐ New Enrollee/Subscriber
- Effective Date / /
- Date of Hire / /

Change - *Check all that apply.*
- ☐ Add Spouse
- ☐ Add Dependent Child
- ☐ Name Change
- ☐ Other
- ☐ Change Plan ______
- ☐ Control/Suffix/Acct/Plan ______

Date of Event / /
Reason ______

Remove or Terminate - *Check all that apply.*
- ☐ Remove Spouse
- ☐ Remove Dependent Child
- ☐ Employee Withdrawal/ Termination

Effective Date / /
Reason ______

Continuation of Coverage, i.e., COBRA, State - *Not all options are available. Contact Employer for available options.*
- Coverage For: ☐ Employee ☐ Dependents
- Length of Continuation (months): ☐ 18 ☐ 36 ☐ Other ____
- ☐ 29 - Attach disability determination from the Social Security Admin.
- Date of Loss of Coverage / /
- Date of Qualifying Event / /
- Continuation of Coverage Expiration Date / /

B. Employee Information

Social Security Number	Last Name, First Name, M.I.		Home Telephone ( )
Home Address	Apt. No.	City, State	ZIP Code
Employer Name			Work Telephone ( )
Work Address		City, State	ZIP Code

C. Plan Options - Your selection(s) must be offered by your employer.

- ☐ HMO ☐ QPOS®
- ☐ Aetna Open Access™ HMO
- ☐ Aetna Choice™ POS
- ☐ AHF Choice POS
- ☐ Aetna Health Network Option℠
- ☐ Aetna Health Network Only℠

Available options with Aetna Health Network Option and Aetna Health Network Only. Check all that apply.
- ☐ Aetna HealthFund™
- ☐ Aexcel®
- ☐ Aexcel® Plus

Indicate Plan Name

Primary Copay: ☐ $5 ☐ $10 ☐ $15 ☐ Other $ ____

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage.

** Provide details for "Yes" responses below.* Attach sheet to list additional children. Attach proof if full-time college student.

(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex M F	Birthdate MM DD YYYY	Social Security Number (If dependent has no SSN, write "None")	Other Medical Coverage	Other Rx Drug Coverage	Handi-capped	Student	Primary Medical Office ID Number	Current Patient	Dentist Office ID Number (If applicable)	Current Patient	Race/Ethnicity - Optional: Code	Other
	Employee	☐ ☐	/ /		Yes * ☐	Yes * ☐	Yes N/A	Yes N/A		Yes ☐		Yes ☐		
	Spouse	☐ ☐	/ /		☐	☐	☐	☐		☐		☐		
	Child	☐ ☐	/ /		☐	☐	☐	☐		☐		☐		
	Child	☐ ☐	/ /		☐	☐	☐	☐		☐		☐		
	Child	☐ ☐	/ /		☐	☐	☐	☐		☐		☐		

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.)

Using the KEY below, please identify the Race/Ethnicity code for each individual.

KEY:
- **01** - White
- **02** - African American or Black
- **03** - Hispanic or Latino
- **04** - Asian
- **05** - Other (Provide race/ethnicity in "Other" column at left)

1. If "Yes" to **Other Medical Coverage** above, provide effective dates, name & policy number of insurance carrier, HMO, or other source and your **Member Identification Number**.
2. If "Yes" to **Other Rx Drug Coverage** above, provide effective dates, name & policy number of insurance carrier, HMO, or other source and your **Member Identification Number**.
3. Does any dependent listed above live at a different address than the employee? ☐ Yes ☐ No If "Yes," who and what address?
   Explain the circumstances:
4. If any dependent's last name differs from yours, explain the circumstances.
5. Is your spouse employed? ☐ Yes ☐ No If "Yes," provide name and address of spouse's employer.

E. Employee Signature

☐ *By checking this box you agree to use Aetna Navigator, Aetna's member self-service website, for all future printed materials and understand you may choose to receive paper documents in the future.*

If you have questions concerning the benefits provided by or excluded under this Agreement, contact a Member Services representative at 1-800-323-9930 before signing this form.

I certify that all information supplied in this form is true and complete to the best of my knowledge and/or belief. I have read and agree to the Conditions of Enrollment on the reverse side of this Enrollment/Change Request form.

Employee Signature - *Required*
X

Date / / E-Mail Address

Primary Language Spoken

Employee copy may be used as a temporary ID card for 30 days from the effective date if authorized by employer. Coverage must be verified with Aetna prior to visiting a specialist or admission to a hospital.

Please make a copy for your records. **visit us at www.aetna.com**

CT, DC, DE, MA, NV, TN
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