

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



## Florida Group Business (2 - 50 Eligible Employees) Employee Enrollment/Change Form

Life, Accidental Death & Personal Loss, Disability, Aetna Managed Choice, and Aetna PPO plans are underwritten by Aetna Life Insurance Company. Aetna HMO and Aetna POS plans are underwritten by Aetna Health Inc. Dental plans are provided or administered by Aetna Life Insurance Company.

**INSTRUCTIONS:** Please be thorough and complete all sections that apply. You are solely responsible for its accuracy and completeness.

**Member Aetna ID Number (if available)**

<b>Company Name:</b> _____				
<b>Effective Date</b>	<input type="checkbox"/> New Hire <input type="checkbox"/> Rehire/Reinstatement	<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 <input type="checkbox"/> Cancel Coverage	<input type="checkbox"/> COBRA <input type="checkbox"/> State 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 _____ Original Qualifying Event Date _____ Qualifying Event _____
<b>Date of Hire</b>	<input type="checkbox"/> New Group Enrollment <input type="checkbox"/> Late Enrollment <input type="checkbox"/> Other _____	<input type="checkbox"/> Name Change <input type="checkbox"/> Other _____		

**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
<b>1. Medical:</b>				
<input type="checkbox"/> <b>Aetna HNOonly (HMO OA)</b> – Plan Option: _____ <input type="checkbox"/> <b>Aetna HNOption (POS OA)</b> – Plan Option: _____ <input type="checkbox"/> <b>Aetna Value Pick</b> – Plan Option: _____ <input type="checkbox"/> <b>Aetna Savings Plus (HMO GK)</b> – Plan Option: _____ <input type="checkbox"/> <b>Aetna Managed Choice Open Access</b> – Plan Option: _____ <input type="checkbox"/> <b>Other</b> – Plan Option: _____				

Control/Group No.	Suffix	Account	Plan No.	Class Code
<b>2. Dental - Check one (if applicable):</b>				
<b>Standard Plans:</b>		<b>Voluntary Plans:</b>		
<input type="checkbox"/> <b>Aetna Dental® Plan</b> – Plan Option: _____ <input type="checkbox"/> <b>Freedom of Choice:</b> <input type="checkbox"/> Managed Dental or <input type="checkbox"/> PPO		<input type="checkbox"/> <b>Aetna Dental® Plan</b> – Plan Option: _____ <input type="checkbox"/> <b>Freedom of Choice:</b> <input type="checkbox"/> Managed Dental 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.	Class Code
<b>3. Life and Disability - Check applicable boxes.</b>				
<input type="checkbox"/> Basic Life/AD&D Ultra® <input type="checkbox"/> Optional Dependent Life <input type="checkbox"/> Disability <input type="checkbox"/> Life/Disability Packaged Plan				
<b>Full Beneficiary Name</b> (First, Middle, Last)			<b>Beneficiary Social Security Number</b>	<b>Birthdate</b> (MM/DD/YYYY) / /
<b>Beneficiary Address</b> (Number, Street, <b>Apt. No.</b> , City, State, ZIP Code)			<b>Telephone Number</b> ( ) -	<b>Relationship to Employee</b>

**B. Employee Information – If you are waiving coverage, complete sections B and F.**

<b>Social Security Number</b>	Last Name, First Name, M.I.	Job Title
Home Address (PO Box not acceptable)		Apt. No.
City, State		ZIP Code
Work Address (PO Box not acceptable)		City, State
ZIP Code		
Home Telephone ( ) -	Work Telephone ( ) -	Primary Language Spoken (Optional)
Number of Dependents including Spouse enrolling for coverage		
<b>Salary</b> \$ _____	<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	<b>No. of Hours Worked Per Week</b> <input type="checkbox"/> 1099 <input type="checkbox"/> Seasonal <input type="checkbox"/> COBRA <input type="checkbox"/> Part-Time <input type="checkbox"/> Retired <input type="checkbox"/> Temporary <input type="checkbox"/> Union

**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.

**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.**

1	(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		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		
2	(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		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		
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		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		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		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		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		

**D. Dependent Information**

List any dependent in Section C living at another address.			
<b>Name</b>	<b>Address</b>		
<b>For Dependent Life Coverage:</b> If age 19 and over and a full-time student, provide the following:			
<b>Child Name</b>	<b>School Name</b>	<b>Expected Graduation Date</b>	<b>Number of Credit Hours</b>

**E. Coordination of Benefits**

Will you have other health insurance at the same time as this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Name of Person</b>	<b>Carrier Name</b>	<b>Name of Person</b>	<b>Carrier Name</b>

**F. 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.		Print Employee Name
<input type="checkbox"/> <b>Medical declined for:</b> <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> <b>Dental declined for:</b> <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> <b>Life declined for:</b> <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> <b>Disability declined for:</b> <input type="checkbox"/> Myself	<b>Reason for declining coverage</b> <input type="checkbox"/> Spousal group coverage <input type="checkbox"/> Parental group coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Retiree coverage <input type="checkbox"/> Another group plan provided by my employer	<input type="checkbox"/> COBRA coverage <input type="checkbox"/> Insurance through another job <input type="checkbox"/> TRICARE/Military <input type="checkbox"/> Individual coverage – On or Off Exchange <input type="checkbox"/> Do not want <input type="checkbox"/> 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		
<b>Please sign here ONLY if you are declining coverage for yourself and/or your dependent(s).</b>		<b>Date (Month/Day/Year)</b>
Employee Signature <b>X</b>		

**Conditions of Enrollment**

On behalf of myself and the dependents listed on Page 2:

- 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: Aetna Health Inc.
  - Life, Accidental Death & Personal Loss, disability, dental and all other health coverages: Aetna Life Insurance Company.
- 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 employer applications have been accepted and approved by Aetna.  
**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.
- I understand and agree that this Enrollment/Change Request 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 or pharmacy database benefit managers to give to Aetna or its agent information concerning the medical history, prescription utilization history, services or treatment provided to anyone listed on this Enrollment/Change Request form, including those involving mental health and substance abuse. 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 twenty-four (24) months. 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. I may revoke my authorization to disclose nonpublic personal health information at any time. I can make this revocation by completing and returning to Aetna a Revocation of Authorization form that will be sent to me by Aetna upon my request. Aetna also will accept a form developed by my employer or my hand-written request for revocation of authorization. However, the employer form or my request must include all the data elements that are included in Aetna's standard revocation form.

continued on next page

**Conditions of Enrollment (continued)**

- 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 Managed Dental 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. To the best of my knowledge and belief, I represent that all information supplied in this form is true and complete. On behalf of myself and the eligible persons listed herein, I acknowledge that I have read and understand this form in its entirety.

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 **Florida** Group Business 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.

**Fraud Statement: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.**

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