New York
Employee Enrollment/Change Form

AETNA LIFE INSURANCE COMPANY
151 Farmington Avenue
Hartford, CT 06156

AETNA HEALTH INSURANCE COMPANY OF NEW YORK
151 Farmington Avenue
Hartford, CT 06156

INSTRUCTIONS: You must complete this enrollment form in full. If you do not, we will return it to you, and that can delay its processing. You alone are responsible for its accuracy and completeness. **If you are declining coverage, you must complete section C.** Please use only black ink to complete this form.

Employer group information – To be completed by employer	Aetna member ID number (if available)
Employer/company name – full name of business or organization	
Employer address (street, city, state, ZIP code) – primary location of business or organization	

A. Type of activity – Employee completes sections A – F. ***Please print clearly.***

Effective date	☐ New hire	☐ Add spouse	☐ Employee termination date
	☐ Rehire/reinstatement	☐ Add domestic partner	_____
	☐ New group enrollment	☐ Add dependent child	☐ Remove spouse
	☐ Late enrollment	☐ Change of coverage	☐ Remove domestic partner
Date of hire	☐ Waiver	☐ Name change	☐ Remove dependent child
	☐ Open enrollment		☐ Cancel coverage
	☐ Loss of coverage		☐ Other _____

☐ **COBRA** ☐ **State continuation** for: ☐ Employee ☐ Dependent Length of continuation: ☐ 18 months ☐ 36 months ☐ Other ____
Qualifying event _____ Original qualifying event date _____ Loss of coverage date _____

B. Employee information – ***You must complete this section.***

Social Security number	Last name, first name, middle initial		Job title	
Home address	Apt. number	City, state		ZIP code
Work address		City, state		ZIP code
Home/cell telephone ( ) -	Work telephone ( ) -	Number of hours worked a week	Employee email	
Primary language spoken (optional)	Check one: ☐ Full time ☐ Part time	☐ 1099 ☐ Retiree	☐ Seasonal ☐ Temporary	☐ COBRA ☐ Union

C. Declining coverage – *Check all that apply.*

I understand I am eligible to apply for this coverage through my employer. However, I am declining the coverage I checked below:

☐ Employee:	☐ Medical ☐ Vision	☐ Dental	**Reason for declining coverage** ☐ Parental group coverage ☐ Spouse/domestic partner group coverage ☐ Medicare ☐ Medicaid ☐ Retiree coverage ☐ COBRA coverage
☐ Spouse/domestic partner:	☐ Medical ☐ Vision	☐ Dental	☐ Insurance through another job ☐ TRICARE/Military coverage ☐ Individual coverage – On Exchange ☐ Individual coverage – Off Exchange ☐ Another group plan provided by my employer ☐ Do not want ☐ Other _____
☐ Children:	☐ Medical ☐ Vision	☐ Dental	

I certify I have the right to apply for this coverage. However, I am declining 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.

Please sign here ONLY if you are declining coverage for yourself and/or dependents. | ***Date (Month/Day/Year)***

☐ I am declining coverage. **Employee signature:** X

Please PRINT employee name:

D. Plan Options – Check one plan. *Your selection must be offered by your employer.*

Control number	Suffix	Account	Plan number	Customer Code

1. Medical ☐ Yes ☒ No *To enroll, check "yes" and enter the plan option elected below. Please print clearly.*

Plan option WE DO NOT OFFER MEDICAL THROUGH AETNA

You may only select a plan offered by your employer.

*Aetna Life Insurance Company and/or Aetna Health Insurance Company **of New York** underwrites/administers medical coverage.*

Control number	Suffix	Account	Plan number

2. Dental ☐ Yes ☐ No *To enroll, check "yes" and enter the plan option elected below. Please print clearly.*

Plan option/name OPTION 13A; PPO 1500 80TH If FOC, choose: ☐ DMO® *or* ☒ PPO/Indemnity

You may only select a dental plan if your employer offers dental coverage.

Employees in AZ, CA, GA, MA, MD, MO, NC, NJ and TX must either live or work within the approved DMO® service area to be eligible to enroll in the DMO®.

Aetna Life Insurance Company underwrites the Aetna dental plans.

Control number	Suffix	Account	Plan number

3. Aetna Vision℠ Preferred ☐ **Yes** ☒ **No** *To enroll, check "yes" and enter the plan option elected below. Please print clearly.*

Plan option/name WE DO NOT OFFER VISION THROUGH AETNA

You may only select a vision plan if your employer offers vision coverage.

Aetna Life Insurance Company underwrites Vision insurance plans. First American Administrators, Inc. provides certain claims administration services. EyeMed Vision Care, LLC ("EyeMed") provides certain network administration services.

E. Individuals covered – *List individuals for whom you are enrolling or adding, changing or removing coverage. Please complete all information for all individuals. Add more sheets if needed.* **NOTE FOR MEDICAL COVERAGE:** While the Affordable Care Act mandates coverage of dependent children up to age 26, your plan may allow coverage beyond age 26. Please refer to your plan documents or contact your benefits administrator. Enter domestic partner only if your employer has elected that coverage.

1	☐ Add ☐ Change ☐ Remove	**Employee name** (Last, first, middle initial)	Sex (M/F/Nonbinary)
Birthdate (MM/DD/YYYY) / /	Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally separated	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision	
Dental provider office ID number			Current patient ☐ Yes
Primary office ID number *(if applicable)*	Physician first and last name	Provider ID number (*if applicable*)	Current patient **Yes** ☐

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E. Individuals covered *(Continued)*

2 ☐ Add ☐ Change ☐ Remove

Name (Last, first, middle initial) ☐ **Spouse** ☐ **Domestic partner** | Sex (M/F/Nonbinary) | Social Security number

Birthdate (MM/DD/YYYY) / / | Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision

Dental provider office ID number | Current patient ☐ Yes

Primary office ID number *(if applicable)* | Physician first and last name | Provider ID number (*if applicable*) | Current patient **Yes** ☐

3 ☐ Add ☐ Change ☐ Remove

Name (Last, first, middle initial) ☐ **Child** ☐ **Stepchild** ☐ **Other** _____ | Sex (M/F/Nonbinary) | Social Security number

Birthdate (MM/DD/YYYY) / / | Incapacitated ☐ Yes ☐ No | Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision

Dental provider office ID number | Current patient ☐ Yes

Primary office ID number *(if applicable)* | Physician first and last name | Provider ID number (*if applicable*) | Current patient **Yes** ☐

4 ☐ Add ☐ Change ☐ Remove

Name (Last, first, middle initial) ☐ **Child** ☐ **Stepchild** ☐ **Other** _____ | Sex (M/F/Nonbinary) | Social Security number

Birthdate (MM/DD/YYYY) / / | Incapacitated ☐ Yes ☐ No | Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision

Dental provider office ID number | Current patient ☐ Yes

Primary office ID number *(if applicable)* | Physician first and last name | Provider ID number (*if applicable*) | Current patient **Yes** ☐

5 ☐ Add ☐ Change ☐ Remove

Name (Last, first, middle initial) ☐ **Child** ☐ **Stepchild** ☐ **Other** _____ | Sex (M/F/Nonbinary) | Social Security number

Birthdate (MM/DD/YYYY) / / | Incapacitated ☐ Yes ☐ No | Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision

Dental provider office ID number | Current patient ☐ Yes

Primary office ID number *(if applicable)* | Physician first and last name | Provider ID number (*if applicable*) | Current patient **Yes** ☐

6 ☐ Add ☐ Change ☐ Remove

Name (Last, first, middle initial) ☐ **Child** ☐ **Stepchild** ☐ **Other** _____ | Sex (M/F/Nonbinary) | Social Security number

Birthdate (MM/DD/YYYY) / / | Incapacitated ☐ Yes ☐ No | Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision

Dental provider office ID number | Current patient ☐ Yes

Primary office ID number *(if applicable)* | Physician first and last name | Provider ID number (*if applicable*) | Current patient **Yes** ☐

F. Dependent information

List any dependent in section **E** with a different last name or living at another address.

Name	Address

G. Coordination of benefits

Will you have other health insurance at the same time as this coverage? ☐ Yes ☐ No

If **yes**, will the Aetna coverage you're applying for replace the coverage you have now? ☐ Yes ☐ No

Name of person	Carrier name	Name of person	Carrier name

Conditions of enrollment

I acknowledge that by enrolling in an Aetna plan, coverage is underwritten or administered by Aetna Life Insurance Company and/or Aetna Health Insurance Company of New York (referred to as "Aetna"). For Vision coverage, First American Administrators, Inc. provides certain claims administration services. EyeMed Vision Care, LLC ("EyeMed") provides certain network administration services.

1. My employer's application determines coverage. I don't have coverage until Aetna approves my employee enrollment form and the employer application. Even if Aetna approves the employer application, material misstatements or omissions may result in denial of future claims. Aetna may rescind or reevaluate my coverage under the policy, as of the effective date, for eligibility and rating purposes. If Aetna voids or rescinds coverage, I may be entitled to a refund of any paid premiums from the effective date of coverage. Aetna will give at least 30 days advance written notice to any covered person affected by the proposed rescission. If I elect to receive electronic notifications, I will receive this notice in an electronic (email) format.
2. To support the coverages listed on this enrollment form, Aetna may need information about medical history, services or treatment provided to anyone listed on this form, excluding drug and alcohol records and psychotherapy notes. In accordance with HIPAA regulations, I authorize that the following entities can provide this information to Aetna or its agents:
   - Physicians
   - Other healthcare professionals
   - Hospitals
   - Other healthcare organizations ("providers"), including
     - Pharmacies
     - Pharmacy database benefit managers
3. In accordance with HIPAA regulations, I authorize Aetna to use and disclose such minimally necessary information to:
   - Affiliates
   - Providers
   - Other insurers
   - Third party administration
   - Vendors
   - Consultants
   - Governmental authorities with jurisdiction when necessary for:
     - Care or treatment
     - Payment for services
     - Operation of my health plan
     - Conduct related activities

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Conditions of enrollment *(Continued)*

4. I discussed the terms of this authorization with my competent adult dependents. This authorization is valid for 24 months from the signature date. This authorization is valid for the term of the coverage for medical information collected in connection with a medical claim. This authorization is voluntary. But if I don't sign this form, my ability to enroll in the plan may be affected. I have the right to revoke this authorization in writing to Aetna at any time. I can't revoke authorization for information already used or disclosed before I revoked my authorization. I am entitled to receive a copy of this authorization upon request. A photocopy is as valid as the original.
   - The Group Agreement/Group Policy determines the rights and responsibilities of members and will govern in the event they conflict with any:
     - Benefits comparison
     - Summary
     - Other description of the plan
   - I understand and agree that, with the exception of members of the CVS Health family of companies (which includes CVS Pharmacy, CVS Caremark Mail Service Pharmacy, MinuteClinic and CVS Specialty Infusion Services), all other participating providers and vendors are independent contractors and are neither agents nor employees of Aetna or its affiliates. We cannot guarantee the availability of any particular provider outside of our corporate family and the providers in our network may change. We also do not guarantee any results or outcome of a health or dental care service. Notice of any change shall be provided in accordance with applicable state law. I understand that, with certain exceptions described in the plan documents, HMO and DMO© plans only provide coverage for covered benefits. The plan documents also describe if I need a referral for certain procedures, and who can provide care. Covered services must be performed by:
   - Participating primary care physicians
   - Participating primary care dentists
   - Participating specialists
   - Participating hospitals
   - Participating pharmacies
   - Participating dentists
   - Other participating providers as authorized by a referral from a participating primary care physician
5. I authorize the substitution of generic pharmaceuticals for the brand-name products, as provided by law, for prescriptions filled under any pharmacy benefit.

I represent that all information supplied in this form is true and complete to the best of my knowledge and belief. I agree to the conditions of enrollment and misrepresentation statement on this Employee Enrollment Form. I understand that, if I don't sign this form within 31 days, or Aetna does not receive the request within a reasonable time, my eligibility may be affected.

I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments required for coverage.

To receive documents online, please visit your secure member account at aetna.com.

Misrepresentation: 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.

Please sign here ONLY if you are enrolling in coverage for yourself and/or dependents. ***Employee signature (required)*** **X**	***Date (Month/Day/Year)***
Spouse / domestic partner signature **X**	***Date (Month/Day/Year)***
Dependent child over the age of majority **X**	***Date (Month/Day/Year)***
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