



# AETNA LIFE INSURANCE COMPANY

151 Farmington Avenue  
Hartford, CT 06156

# AETNA HEALTH INSURANCE COMPANY OF NEW YORK

151 Farmington Avenue  
Hartford, CT 06156

## New York Small Group Business Employee Enrollment/Change Form for Medical, Dental and Vision Coverage

The above address is the corporate address. Please do not mail any correspondence to this address.

**INSTRUCTIONS:** You, the employee, 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 E. Please use only black ink to complete this form.**

Aetna member ID number (if available)

<b>Company name</b>			
<b>Effective date</b>	<input type="checkbox"/> New hire	<input type="checkbox"/> Add spouse	<input type="checkbox"/> Employee termination
	<input type="checkbox"/> Rehire / reinstatement	<input type="checkbox"/> Add domestic partner	<input type="checkbox"/> Remove spouse
<b>Date of hire</b>	<input type="checkbox"/> New group enrollment	<input type="checkbox"/> Add dependent child	<input type="checkbox"/> Remove domestic partner
	<input type="checkbox"/> Late enrollment	<input type="checkbox"/> Change of coverage	<input type="checkbox"/> Remove dependent child
	<input type="checkbox"/> Waiver	<input type="checkbox"/> Name change	<input type="checkbox"/> Cancel coverage
	<input type="checkbox"/> Open enrollment		<input type="checkbox"/> Other _____
	<input type="checkbox"/> Loss of coverage		
<input type="checkbox"/> <b>COBRA</b> <input type="checkbox"/> <b>Continuation for:</b> <input type="checkbox"/> Employee <input type="checkbox"/> Dependent   Length of continuation: <input type="checkbox"/> 18 months <input type="checkbox"/> 36 months <input type="checkbox"/> Other _____ Qualifying event _____ Original qualifying event date _____ Loss of coverage date _____			

### A. Employee information – You must complete this section.

<b>Social Security number</b>	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 ( ) -	Primary language spoken (optional)	Number of dependents (including spouse or domestic partner) enrolling for medical coverage
<b>Marital status</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally separated	Number of hours worked a week	<b>Check one</b> <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>Employee email</b>			

**B. Coverage selection – Top boxes for employer and Aetna use only**

Control/Group number	Suffix	Account	Plan number	Class code
<b>1. Medical</b>				
<input type="checkbox"/> Signature Open Access Elect Choice® (OAEPO) – Plan option _____				
<input type="checkbox"/> Open Access Elect Choice® (OAEPO) – Plan option _____				
<input type="checkbox"/> Open Access Elect Choice® (OAEPO) HSA Compatible CY (Calendar Year) – Plan option _____				
<input type="checkbox"/> Open Access Elect Choice® (OAEPO) HSA Compatible PY (Plan Year) – Plan option _____				
<input type="checkbox"/> Aetna Whole Health Open Access Elect Choice® (OAEPO) – Plan option _____				
<input type="checkbox"/> Aetna Whole Health Open Access Elect Choice® (OAEPO) HSA Compatible – Plan option _____				
<input type="checkbox"/> Other – Plan option _____				

Aetna Health Insurance Company of New York underwrites Signature EPO plans. Aetna Life Insurance Company underwrites all other Aetna EPO plans.

Control/Group number	Suffix	Account	Plan number
<b>2. Dental</b>			
Non-voluntary Plans: Option _____		FOC: <input type="checkbox"/> DMO® or <input type="checkbox"/> PPO	
Voluntary Plans: Option _____		FOC: <input type="checkbox"/> DMO® or <input type="checkbox"/> PPO	
<b>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®.</b>			

Aetna Life Insurance Company underwrites Aetna dental plans.

Control/Group number	Suffix	Account	Plan number
<b>3. Vision</b> Check box if applicable.			
Aetna Vision <sup>SM</sup> Preferred <input type="checkbox"/> Yes <input type="checkbox"/> No			

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

**C. Individuals covered - List individuals for whom you are enrolling or adding, changing or removing coverage. 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.

<b>1</b>	<b>Employee name</b> (Last, first, middle initial)	Sex (M/F/Nonbinary)	<b>Birthdate</b> (MM/DD/YYYY) / /	
Choosing coverage for: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		Dental office ID number (if applicable)	Current patient Yes <input type="checkbox"/>	
Primary office ID number (if applicable)		Physician first and last name	Provider ID number (if applicable)	Current patient Yes <input type="checkbox"/>
<b>2</b>	<b>Spouse/Domestic partner</b> (Last, first, middle initial)	Sex (M/F/Nonbinary)	<b>Social Security number</b>	<b>Birthdate</b> (MM/DD/YYYY) / /
Choosing coverage for: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		Dental office ID number (if applicable)	Current patient Yes <input type="checkbox"/>	
Primary office ID number (if applicable)		Physician first and last name	Provider ID number (if applicable)	Current patient Yes <input type="checkbox"/>
<b>3</b>	<b>Child</b> (Last, first, middle initial)	Sex (M/F/Nonbinary)	<b>Social Security number</b>	<b>Birthdate</b> (MM/DD/YYYY) / /
Choosing coverage for: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		Out of area Yes <input type="checkbox"/>	Dental office ID number (if applicable)	Current patient Yes <input type="checkbox"/>
Primary office ID number (if applicable)		Physician first and last name	Provider ID number (if applicable)	Incapacitated Yes <input type="checkbox"/> No <input type="checkbox"/> Current patient Yes <input type="checkbox"/>

Continued on next page

**C. Individuals covered (Continued)**

<b>4</b>	<b>Child</b> (Last, first, middle initial)	Sex (M/F/Nonbinary)	<b>Social Security number</b>	<b>Birthdate</b> (MM/DD/YYYY) / /	
Choosing coverage for: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		Out of area <b>Yes</b> <input type="checkbox"/>	Dental office ID number (if applicable)	Current patient <b>Yes</b> <input type="checkbox"/>	Incapacitated Yes <input type="checkbox"/> No <input type="checkbox"/>
Primary office ID number (if applicable)		Physician first and last name		Provider ID number (if applicable)	
				Current patient <b>Yes</b> <input type="checkbox"/>	
<b>5</b>	<b>Child</b> (Last, first, middle initial)	Sex (M/F/Nonbinary)	<b>Social Security number</b>	<b>Birthdate</b> (MM/DD/YYYY) / /	
Choosing coverage for: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		Out of area <b>Yes</b> <input type="checkbox"/>	Dental office ID number (if applicable)	Current patient <b>Yes</b> <input type="checkbox"/>	Incapacitated Yes <input type="checkbox"/> No <input type="checkbox"/>
Primary office ID number (if applicable)		Physician first and last name		Provider ID number (if applicable)	
				Current patient <b>Yes</b> <input type="checkbox"/>	
<b>6</b>	<b>Child</b> (Last, first, middle initial)	Sex (M/F/Nonbinary)	<b>Social Security number</b>	<b>Birthdate</b> (MM/DD/YYYY) / /	
Choosing coverage for: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		Out of area <b>Yes</b> <input type="checkbox"/>	Dental office ID number (if applicable)	Current patient <b>Yes</b> <input type="checkbox"/>	Incapacitated Yes <input type="checkbox"/> No <input type="checkbox"/>
Primary office ID number (if applicable)		Physician first and last name		Provider ID number (if applicable)	
				Current patient <b>Yes</b> <input type="checkbox"/>	

**D. Dependent information**

List any dependent in Section C living at another address.

Name	Address

**E. Declining 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 declining the coverage I checked below:

<input type="checkbox"/> Employee:	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<b>Reason for declining coverage</b> <input type="checkbox"/> Spousal / domestic partner group coverage <input type="checkbox"/> Insurance through another job <input type="checkbox"/> Parental group coverage <input type="checkbox"/> Individual coverage - On Exchange <input type="checkbox"/> COBRA coverage <input type="checkbox"/> Individual coverage - Off Exchange <input type="checkbox"/> Medicare <input type="checkbox"/> TRICARE Military coverage <input type="checkbox"/> Medicaid <input type="checkbox"/> VA coverage <input type="checkbox"/> Retiree coverage <input type="checkbox"/> I have no other coverage <input type="checkbox"/> Another group plan provided by my employer <input type="checkbox"/> I do not want <input type="checkbox"/> Other _____
<input type="checkbox"/> Spouse / domestic partner:	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	
<input type="checkbox"/> Children:	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <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 ONLY if you are declining coverage for yourself and / or dependents.**

<b>X</b> Employee signature:	<b>Date (Month/Day/Year)</b>
Please PRINT employee name:	

**F. 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 understand that the following legal entities underwrite the plans I apply for:

- Aetna Health Insurance Company of New York underwrites Aetna Signature EPO plans;
- Aetna Life Insurance Company underwrites all other Aetna EPO plans, Aetna dental plans and Aetna vision plans.

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, any 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. 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 HIPPA regulations, I authorize Aetna to use and disclose such minimally necessary information related to:
  - My care or treatment
  - The payment for services
  - The operation of my health plan
  - Conduct related activities to support my health

Disclosure of this information is limited to:

  - Affiliates (Members of the CVS Health family of companies (which includes CVS Pharmacy, CVS Caremark Mail Service Pharmacy, MinuteClinic and CVS Specialty Infusion Services)
  - Providers
  - Consultants
  - Other Insurers
  - Third party administration
  - Vendors
  - Governmental authorities with jurisdiction
4. I discussed the terms of this authorization with my competent adult dependents. They agreed to these terms. This authorization is valid for 24 months from the signature date. 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.

*Continued on next page*

**Conditions of enrollment (continued)**

5. I understand that, with certain exceptions described in the plan documents, HMO and DMO® plans only provide coverage for network 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
6. 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 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 employee enrollment / change form.

I understand that if I do not sign this form within 31 days, 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 a 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.

To receive documents online, please visit your secure member account at <http://www.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.

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

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