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.

aetna®

Connecticut Employee Enrollment/Change Form
(2 - 50 Eligible Employees)

INSTRUCTIONS: You, the employee, must complete 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. If waiving coverage, please complete Sections B and D.

Member Aetna ID Number (if available)

Company Name

Effective Date / Date of Hire				
	☐ New Hire ☐ Rehire/Reinstatement ☐ New Group Enrollment ☐ Late Enrollment ☐ Other _____	☐ Change of Coverage ☐ Add Spouse/ Civil Union Partner/ Domestic Partner ☐ Add Dependent Child ☐ Name Change ☐ Other _____	☐ Employee Termination ☐ Remove Spouse/ Civil Union Partner/ Domestic Partner ☐ Remove Dependent Child ☐ Cancel Coverage	☐ COBRA ☐ State Continuation for: ☐ Employee ☐ Dependent Length of Continuation: ☐ 30 ☐ 36 ☐ Other ____ Original Qualifying Event Date _____ Qualifying Event _____

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

1. Medical ☐ Yes ☐ No
   - ☐ Open Choice PPO – Plan Option: _____
   - ☐ Aetna Indemnity – Plan Option: _____

Control/Group No.	Suffix	Account	Plan No.

2. Dental ☐ Yes ☐ No

Standard Plans:
Option: _____
If FOC, choose: ☐ DMO® *or* ☐ PPO

Voluntary Plans:
Option: _____
If FOC, choose: ☐ DMO® *or* ☐ PPO

Before today, were you covered under this employer's dental plan? ☐ Yes ☐ No

Control/Group No.	Suffix	Account	Plan No.

3. Life and Disability ☐ Yes ☐ No *Check applicable boxes.*

NOTE: Disability coverage is for employee only. Disability plans do not cover dependents.

☐ Basic Life/AD&D Ultra® ☐ Optional Dependent Life
☐ Life & Disability Packaged Plan ☐ Short Term Disability

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

B. Employee Information – *Must be completed by the employee.*

Social Security Number	Last Name, First Name, M.I.	Primary Language Spoken (Optional)

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 ( ) -	No. of Hours Worked Per Week	Number of Dependents (including Spouse/ Civil Union Partner/Domestic Partner) enrolling for coverage

Salary $		Check One				Marital Status	
	☐ Hourly ☐ Weekly ☐ Monthly	☐ Full-Time ☐ Part-Time	☐ 1099 ☐ Retiree	☐ Seasonal ☐ Temporary	☐ COBRA ☐ Union	☐ Married ☐ Single	☐ Civil Union Partner ☐ Domestic Partner

C. Individuals Covered - *List individuals for whom you are enrolling or adding/changing/removing coverage. Add 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 for medical plans and some dental plans, your plan may allow coverage beyond age 26. Some exceptions apply. Please refer to your plan documents or contact your benefits administrator.

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 ☐ Medical ☐ Life ☐ Dental ☐ Disability		Dental Office ID Number (If applicable)	Current Patient Yes ☐
2	(A)dd (C)hange ___ (R)emove	Name (Last, First, M.I.) ☐ Spouse ☐ Civil Union Partner ☐ Domestic Partner	Sex (M/F)	Social Security Number	
Birthdate (MM/DD/YYYY) / /		Coverage Election ☐ Medical ☐ Life ☐ Dental		Dental Office ID Number (If applicable)	Current Patient Yes ☐
3	(A)dd (C)hange ___ (R)emove	Name (Last, First, M.I.) ☐ Child ☐ Stepchild ☐ Other	Sex (M/F)	Social Security Number	
Birthdate (MM/DD/YYYY) / /		Coverage Election ☐ Medical ☐ Life ☐ Dental	Student (Life Only) Yes ☐	Dental Office ID Number (If applicable)	Current Patient Yes ☐
4	(A)dd (C)hange ___ (R)emove	Name (Last, First, M.I.) ☐ Child ☐ Stepchild ☐ Other	Sex (M/F)	Social Security Number	
Birthdate (MM/DD/YYYY) / /		Coverage Election ☐ Medical ☐ Life ☐ Dental	Student (Life Only) Yes ☐	Dental Office ID Number (If applicable)	Current Patient Yes ☐
5	(A)dd (C)hange ___ (R)emove	Name (Last, First, M.I.) ☐ Child ☐ Stepchild ☐ Other	Sex (M/F)	Social Security Number	
Birthdate (MM/DD/YYYY) / /		Coverage Election ☐ Medical ☐ Life ☐ Dental	Student (Life Only) Yes ☐	Dental Office ID Number (If applicable)	Current Patient Yes ☐
6	(A)dd (C)hange ___ (R)emove	Name (Last, First, M.I.) ☐ Child ☐ Stepchild ☐ Other	Sex (M/F)	Social Security Number	
Birthdate (MM/DD/YYYY) / /		Coverage Election ☐ Medical ☐ Life ☐ Dental	Student (Life Only) Yes ☐	Dental Office ID Number (If applicable)	Current Patient Yes ☐

D. Declination/Waiver of Coverage – *To be completed if medical and/or dental 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.

☐ Waive **Medical** coverage for:
- ☐ Myself ☐ Child(ren)
- ☐ Spouse/Civil Union/Domestic Partner

☐ Waive **Dental** coverage for:
- ☐ Myself ☐ Child(ren)
- ☐ Spouse/Civil Union/Domestic Partner

☐ Waive **Life** coverage for:
- ☐ Myself ☐ Child(ren)
- ☐ Spouse/Civil Union/Domestic Partner

☐ Waive **Disability** coverage for: ☐ Myself

Reason for declining coverage:

- ☐ Spouse/Civil Union/Domestic Partner group coverage
- ☐ Parental group coverage
- ☐ Medicare
- ☐ Medicaid
- ☐ Retiree coverage
- ☐ Another group plan provided by my employer
- ☐ COBRA coverage
- ☐ Insurance through another job
- ☐ TRICARE
- ☐ Individual coverage – On or Off Exchange
- ☐ Do not want
- ☐ 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.

Please sign here ONLY if you are declining coverage for yourself and/or dependent(s)	*Date (Month/Day/Year)*
Employee Signature X	

E. Dependent Information

List any dependent in Section D living at another address.

Name	Address

For Dependent Life Coverage: If age +19 and a full-time student, provide the following if enrolling for life coverage:

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. Case management is a process of identifying individuals with certain medical conditions associated with complex health care needs and helps us better provide you with any care you may need.)

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

Name of Individual	Condition(s)

Conditions of Enrollment

On behalf of myself and the dependents listed on Page 2, I agree to or with the following:

1. I acknowledge that by enrolling in an Aetna plan coverage is provided by Aetna Life Insurance Company (referred to as "Aetna").
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 and employer applications have been accepted and approved by Aetna. Even if this enrollment form is approved, any misstatements or omissions 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, subject to the Connecticut incontestability clause with a 2 year limit on information in this application.

   For life 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 19th birthday or up to their 23rd 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"), to give to Aetna or its agent information concerning the medical 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/civil union partner/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 for 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.

continued on next page

Conditions of Enrollment *(Continued)*

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, DMO® 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. In Connecticut, DMO plans provide out-of-network benefits. However, in order to receive maximum benefits, members must select and have care coordinated by a participating primary care dentist. Connecticut DMO is not an HMO.

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.

If you are currently covered by accident and sickness insurance, is this plan intended to replace your current coverage? ☐ Yes ☐ No

To the best of my knowledge and belief, 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 Connecticut 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 30 hours per week (or 20 hours per week if my employer extends coverage) for this employer at the regular place of business.

Employee Signature	*Employee E-mail Address (optional)*	*Date (Month/Day/Yr)*
X		