Aetna®

Enrollment/Change Request

Aetna Health of California Inc.

TO COMPLY WITH CALIFORNIA LAW, WHEREVER THE TERM "SPOUSE" APPEARS, IT SHALL INCLUDE A DOMESTIC PARTNER.

Employer Group Information - To Be Completed by Employer:	Group Name	Group Number	Class Code

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, the employee, 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
- ☐ Change Plan
- ☐ Other

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 / /

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 must be offered by your employer.

Check One:
- ☐ HMO ☐ QPOS®
- ☐ Aetna HealthFund® HMO

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 Yes*	Other Rx Drug Coverage Yes*	Handi-capped Yes N/A	Primary Office ID Number	Current Patient Yes	Dentist Office ID Number (If applicable)	Current Patient Yes	Race/Ethnicity - *Optional* Code	Other
	Employee	☐ ☐	/ /		☐	☐			☐		☐		
	Spouse	☐ ☐	/ /		☐	☐	☐		☐		☐		
	Child	☐ ☐	/ /		☐	☐	☐		☐		☐		
	Child	☐ ☐	/ /		☐	☐	☐		☐		☐		

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

NOTICE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

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 represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the reverse side of this application. **CALIFORNIA HMO APPLICANTS:** Any dispute arising from or related to Health Plan membership will be determined by submission to binding arbitration, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. The agreement to arbitrate includes, but is not limited to, disputes involving alleged professional liability or medical malpractice, that is, whether any medical services covered by the Group Agreement were *unnecessary or were unauthorized or were improperly, negligently or incompetently rendered.* This agreement also limits certain remedies and may limit the award of punitive damages. See Sections "Binding Arbitration" and "Limitations on Remedies" of the Evidence of Coverage for further information. I understand that I am giving up the constitutional right to have disputes decided in a court of law before a jury, and instead am accepting the use of binding arbitration. This means that members will not be able to try their case in court. I further understand that the agreement contains limitations on certain remedies and that members cannot recover punitive damages.

Employee Signature - *Required*	Date	E-Mail Address	Primary Language Spoken
X	/ /		

F. Employer Verification (To Be Completed by Employer)

Employer Signature - *Required*

X

Title

Date / /

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.