

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.



Pennsylvania Employee Enrollment/Change Form (50 or fewer employees)

Group Number
Member Aetna ID Number (if available)

INSTRUCTIONS: You, the employee, must complete this enrollment form 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 A and B.**

Company Name			
Effective Date	<input type="checkbox"/> New Hire <input type="checkbox"/> Rehire/Reinstatement*	<input type="checkbox"/> Add Spouse <input type="checkbox"/> Add Domestic Partner	<input type="checkbox"/> Employee Termination <input type="checkbox"/> Remove Spouse
Date of Hire	<input type="checkbox"/> New Group Enrollment <input type="checkbox"/> Late Enrollment	<input type="checkbox"/> Add Dependent Child <input type="checkbox"/> Change of Coverage	<input type="checkbox"/> Remove Domestic Partner <input type="checkbox"/> Remove Dependent Child
BWP <input type="checkbox"/> Class 1 <input type="checkbox"/> Class 2	<input type="checkbox"/> Waiver <input type="checkbox"/> Open Enrollment <small>* Does not apply to Supplemental or Dependent Life Insurance</small>	<input type="checkbox"/> Name Change	<input type="checkbox"/> Cancel Coverage <input type="checkbox"/> Other _____
<input type="checkbox"/> COBRA <input type="checkbox"/> 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 _____ Qualifying Event _____ Original Qualifying Event Date _____ Loss of Coverage Date _____			

A. Employee Information - Must be completed by the employee.

Social Security Number	Last Name, First Name, M.I.	Job Title	
Home Address	Apt. No.	City, State	ZIP Code
Work Address		City, State	ZIP Code
Home Telephone () -	Work Telephone () -	Primary Language Spoken (Optional)	No. of Hours Worked Per Week
Salary \$	<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	Check One <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. Waiver of 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 waiving coverage as noted below.			
Employee: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life <input type="checkbox"/> Vision <input type="checkbox"/> Disability	Reason for Declining Coverage <input type="checkbox"/> Spouse/Domestic Partner group coverage <input type="checkbox"/> Another group plan provided by my employer <input type="checkbox"/> Parental group coverage <input type="checkbox"/> Insurance through another job <input type="checkbox"/> COBRA coverage <input type="checkbox"/> Individual coverage - On Exchange <input type="checkbox"/> Medicare <input type="checkbox"/> Individual coverage - Off Exchange <input type="checkbox"/> Medicaid <input type="checkbox"/> TRICARE Military coverage <input type="checkbox"/> Retiree coverage <input type="checkbox"/> Do not want <input type="checkbox"/> Other _____		
Spouse: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life <input type="checkbox"/> Vision			
Child(ren): <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life <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 or your dependent(s).			Date (Month/Day/Year)
X Employee Signature			

C. Coverage Selection – Please print clearly, using black ink. (Top boxes for Employer/Aetna-Use Only.)

Control/Group No.	Suffix	Account	Plan No.	Class Code
-------------------	--------	---------	----------	------------

1. Medical Yes No *To enroll, check one and enter the plan option elected following the plan type below.*

PA HMO – Plan Option: _____

PA HMO HSA Compatible – Plan Option: _____

PA HMO Savings Plus – Plan Option: _____

PA QPOS – Plan Option: _____

PA Health Network Option – Plan Option: _____

PA Health Network Option HSA Compatible – Plan Option: _____

PA PPO – Plan Option: _____

PA PPO HSA Compatible – Plan Option: _____

PA AWH PPO – Plan Option: _____

PA AWH PPO HSA Compatible – Plan Option: _____

PA Indemnity – Plan Option: _____

Other Plan – Plan Option: _____

Control/Group No.	Suffix	Account	Plan No.	
-------------------	--------	---------	----------	--

2. Dental Yes No *To enroll, enter the plan number and name elected below.*

Contributory Plans: Plan Number _____ Plan Name: _____ If FOC, choose: DMO® or PPO

Voluntary Plans: Plan Number _____ Plan Name: _____ If FOC, choose: DMO® or PPO

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

Creditable coverage is allowed for new members enrolling in voluntary takeover groups. New hires please see below if applicable:
 New Hire selecting a Voluntary Plan and **your Aetna plan is a takeover group:** Were you covered for 12 months under a dental plan within the last 90 days that included both Preventive and Basic coverage? Discount dental and preventive only plans do not apply. Yes No

Control/Group No.	Suffix	Account	Plan No.	
-------------------	--------	---------	----------	--

3. Life and Disability

Life /AD&PL for groups with 2-9 employees *Check applicable boxes*

Employee Basic Life/AD&PL Ultra

Life /AD&PL for groups with 10-50 employees *Check applicable boxes*

Employee Basic Life/AD&PL Ultra Supplemental Life

Spouse Optional Dependent Life

Child Optional Dependent Life

DESIGNATION OF BENEFICIARY – Carefully review Additional Conditions and Instructions for Designation of Beneficiary on Page 6.

Life Products require the employee to designate a beneficiary for benefits. A beneficiary is the person or entity who will receive the benefit payment. A primary beneficiary will be the first to receive the benefit. A contingent beneficiary will only receive the benefit payment if the primary beneficiary dies or is no longer available. The employee is automatically the primary beneficiary for dependent life and AD&PL benefits.

Beneficiary For:	Full Name(s) or Entity (Trust or Estate)	Date of Birth	Social Security Number / Tax ID Number	Address (Number, Street, Apt. No., City, State, ZIP Code)	Phone	Relationship to Employee	% of Benefit (must equal 100%)
Basic Life Primary							
Basic Life Contingent							
Supplemental Life Primary							
Supplemental Life Contingent							

continued on next page

C. Coverage Selection (Continued)

SPOUSAL CONSENT FOR COMMUNITY PROPERTY STATES – See Additional Conditions and Instructions for Designation of Beneficiary Section on Page 6.

Please note that an Employee is under no obligation to complete the Spousal Consent section on this form.

I am aware that my spouse, the Employee named above, has designated someone other than me to be the beneficiary of group Life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.

Spouse Signature _____ Date _____

Disability - Check applicable boxes. *Employee only*

Short Term Disability for groups with 2-50 employees Yes No

Long Term Disability for groups with 10-50 employees Yes No

Life and Disability Packaged Plan Yes No

Control/Group No.	Suffix	Account	Plan No.
-------------------	--------	---------	----------

4. Vision (if applicable)

Aetna Vision Preferred Yes No *Check applicable box.*

D. Individuals Covered - List individuals for whom you are enrolling or adding/changing/removing coverage. Insert additional sheets if necessary and staple to the back of this application. NOTE FOR MEDICAL 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. 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)	Birthdate (MM/DD/YYYY) / /
Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life <input type="checkbox"/> Disability <input type="checkbox"/> Vision		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		
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 <input type="checkbox"/> Vision		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		
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 <input type="checkbox"/> Vision		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 <input type="checkbox"/> Vision		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	

continued on next page

D. Individuals Covered (continued)

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 <input type="checkbox"/> Vision		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 <input type="checkbox"/> Vision		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		

E. Dependent Information

List any dependent in Section D living at another address.

Name	Address

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.)

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

Conditions of Enrollment

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

1. 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 Network plans and Aetna POS plans: Aetna Health Inc. and/or Aetna Health Insurance Company
 - Aetna PPO and Indemnity plans: Aetna Life Insurance Company
 - Aetna VisionSM Preferred plans: Aetna Life Insurance Company; certain claims adjudication and other administrative services are provided by First American Administrators, Inc. (an affiliate of EyeMed Vision Care, LLC) and/or its affiliates;
 - Life, Accidental Death & Personal Loss, disability, dental and all other coverages: Aetna Life Insurance Company.
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 enrollment form and the employer application have been accepted and approved by Aetna. Even if this enrollment form is approved, any intentional and material misstatements or omissions that amount to fraud, or which would have affected the carrier's rating, offering or issuing of coverage impacted, 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.
For life coverage: 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, dependent children are eligible from birth up to their 26th birthday.
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"), including pharmacies and pharmacy database benefit managers to give Aetna or its agent information concerning the medical history, prescription utilization 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/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 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. This authorization is voluntary. However, I understand that if I refuse to sign this authorization form, my ability to enroll in the medical plans described above may be affected. I have the right to revoke this authorization in writing to Aetna at any time except to the extent that my information has already been used or disclosed in reliance on this authorization. However, because this information is essential to the administration of the plans, I understand that my revocation of this authorization may result in cancellation of my enrollment in the medical plans described above.
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 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.

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.

I represent that all information supplied in this form is true and complete to the best of my knowledge and belief. I have read and agree to the Conditions of Enrollment and Misrepresentation on this **Pennsylvania** 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 eligibility 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. I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments as required for coverage.

If you wish to receive documents electronically, please refer to Aetna Navigator[®] at
<http://www.aetna.com/individuals-families/aetna-navigator.html>.

<i>Employee Signature (Required to enroll)</i> X	<i>Employee E-mail Address</i>	<i>Date (Month/Day/Year) – Required</i>
---	--------------------------------	---

Additional Conditions and Instructions for Designation of Beneficiary

Conditions for Designation of Beneficiary

- **Please note:** The Group Contract grants the member the authority to designate a beneficiary. A beneficiary designated by someone other than the member (i.e., attorney-in-fact, Power of Attorney, guardian, custodian, etc.) may be barred under the Group Contract, by the Power of Attorney executed by the member and/or by state law. The member should execute the beneficiary designation section of this form whenever possible to ensure the designation is deemed valid.
- Unless otherwise expressly provided in the Designation of Beneficiary section of this form, if any named beneficiary predeceases me, the life proceeds shall be payable equally to the remaining named beneficiary or beneficiaries. If no named beneficiary survives me, any sum becoming payable under said Group Policy(ies) by reason of my death shall be payable as prescribed in said Group Policy(ies).
- If this Designation of Beneficiary provides for payment to a trustee under a trust agreement, Aetna Life Insurance Company shall not be obliged to inquire into the terms of the trust agreement and shall not be chargeable with knowledge of the terms thereof. Payment to and receipt by the trustee shall fully discharge all liability of said Insurance Company to the extent of such payment.
- If you live in one of the following community property states – Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin – your spouse may have a legal claim for a portion of the life insurance benefit under state law. If you name someone other than your spouse as beneficiary, payment of the death benefit may be delayed until your spouse's claim is resolved.

Instructions for Designation of Beneficiary

If these instructions do not answer all your questions, please contact your plan sponsor for assistance.

Please use only black ink to complete this form.

- If you make a mistake in completing this form, line out the erroneous information, add the correct information and initial the correction. **The printed material on this form should not be deleted or altered in any way.**
- **In all cases**, the relationship of the beneficiary, the beneficiary's Social Security Number, address and phone number should be included with the beneficiary designations.
- **Dollars and cents should not be specified.**
- If a minor child is named beneficiary, the child will not receive the benefits until age of majority.
- If a trustee is named beneficiary, show the exact name of the trust, date of the trust agreement, and the name and address of the trustee. **For example**, The John J. Smith Revocable Life Insurance Trust, dated January 1, 1994. John Smith, Trustee, 123 Apple Lane, Hartford, CT 06006.