aetna®

AETNA LIFE INSURANCE COMPANY

151 Farmington Avenue
Hartford, CT 06156

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

FOR GROUP COVERAGE (1–100 FULL TIME EQUIVALENT EMPLOYEES)

DMO® and PPO dental plans, Aetna OAMC plans, Aetna EPO plans, Aetna Indemnity, Aetna Vision℠ Preferred plans and Aetna NYC Community Plan℠ are provided by Aetna Life Insurance Company. For Vision coverage, certain claims administration services are provided by First American Administrators, Inc. and certain network administration services are provided through EyeMed Vision Care, LLC ("EyeMed").

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)

Company name

Effective date

Date of hire

Benefit waiting period*
☐ Class 1 ☐ Class 2
*Only required when your employer has 2 benefit waiting periods

☐ New hire
☐ Rehire / reinstatement
☐ New group enrollment
☐ Late enrollment
☐ Waiver
☐ Open enrollment
☐ Loss of coverage

☐ Add spouse
☐ Add domestic partner
☐ Add dependent child
☐ Change of coverage
☐ Name change

☐ Employee termination
☐ Remove spouse
☐ Remove domestic partner
☐ Remove dependent child
☐ Cancel coverage
☐ Other _____

☐ **COBRA** ☐ **Continuation for:** ☐ Employee ☐ Dependent Length of continuation: ☐ 18 months ☐ 36 months ☐ Other _____

Qualifying event _____ Original qualifying event date _____ Loss of coverage date _____

A. 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 telephone ( ) -	Work telephone ( ) -	Primary language spoken (optional)	Number of dependents (including spouse or domestic partner) enrolling for medical coverage

Marital status
☐ Single ☐ Married
☐ Divorced ☐ Widowed
☐ Legally separated

Number of hours worked a week

Check one
☐ Full time ☐ Part time ☐ 1099 ☐ Retired
☐ Seasonal ☐ Temporary ☐ Union ☐ COBRA

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

Control/Group number	Suffix	Account	Plan number	Class code

1. Medical

- ☐ Open Access Managed Choice® (OAMC) HSA Compatible – Plan option: _____
- ☐ Open Access Managed Choice® (OAMC) HSA Compatible FH – Plan option: _____
- ☐ Open Access Elect Choice® (OAEPO) – Plan option: _____
- ☐ Open Access Elect Choice® (OAEPO) HSA Compatible – Plan option: _____
- ☐ Savings Plus Open Access Elect Choice® (OAEPO) – Plan option: _____
- ☐ EPO – Plan option: _____
- ☐ Aetna Whole Health (AWH) OAEPO – Plan option: _____
- ☐ NYC Community Plan℠ – Plan option: _____
- ☐ Indemnity (only available if PPO networks are not available) – Plan option: _____
- ☐ Other – Plan option: _____

Control/Group number	Suffix	Account	Plan number

2. Dental

Non-voluntary Plans: Option: _____ FOC: ☐ DMO® *or* ☐ PPO

Voluntary Plans: Option: _____ FOC: ☐ 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 number	Suffix	Account	Plan number

3. Vision *Check box if applicable.*

Aetna Vision Preferred ☐ Yes ☐ No

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.

1	**Employee name** (Last, first, middle initial)	Sex (M/F)	**Birthdate** (MM/DD/**YYYY**) / /

Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision	Dental office ID number *(if applicable)*	Current patient **Yes** ☐
Primary office ID number *(if applicable)* / Physician first and last name	Provider ID number (*if applicable*)	Current patient **Yes** ☐

2	**Spouse/Domestic partner** (Last, first, middle initial)	Sex (M/F)	**Social Security number**	**Birthdate** (MM/DD/**YYYY**) / /

Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision	Dental office ID number *(if applicable)*	Current patient **Yes** ☐
Primary office ID number *(if applicable)* / Physician first and last name	Provider ID number (*if applicable*)	Current patient **Yes** ☐

3	**Child** (Last, first, middle initial)	Sex (M/F)	**Social Security number**	**Birthdate** (MM/DD/**YYYY**) / /

Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision	Out of area **Yes** ☐	Dental office ID number *(if applicable)*	Current patient **Yes** ☐	Incapacitated Yes ☐ No ☐
Primary office ID number *(if applicable)* / Physician first and last name		Provider ID number (*if applicable*)		Current patient **Yes** ☐

4	**Child** (Last, first, middle initial)	Sex (M/F)	**Social Security number**	**Birthdate** (MM/DD/**YYYY**) / /

Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision	Out of area **Yes** ☐	Dental office ID number *(if applicable)*	Current patient **Yes** ☐	Incapacitated Yes ☐ No ☐
Primary office ID number *(if applicable)* / Physician first and last name		Provider ID number (*if applicable*)		Current patient **Yes** ☐

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C. Individuals covered *(Continued)*

5	**Child** (Last, first, middle initial)	Sex (M/F)	**Social Security number**	**Birthdate** (MM/DD/**YYYY**) / /
Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision		Out of area **Yes** ☐	Dental office ID number *(if applicable)*	Current patient **Yes** ☐ / Incapacitated Yes ☐ No ☐
Primary office ID number *(if applicable)*	Physician first and last name		Provider ID number (*if applicable*)	Current patient **Yes** ☐

6	**Child** (Last, first, middle initial)	Sex (M/F)	**Social Security number**	**Birthdate** (MM/DD/**YYYY**) / /
Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision		Out of area **Yes** ☐	Dental office ID number *(if applicable)*	Current patient **Yes** ☐ / Incapacitated Yes ☐ No ☐
Primary office ID number *(if applicable)*	Physician first and last name		Provider ID number (*if applicable*)	Current patient **Yes** ☐

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:

☐ Employee: ☐ Medical ☐ Dental ☐ Vision

☐ Spouse / domestic partner: ☐ Medical ☐ Dental ☐ Vision

☐ Child(ren): ☐ Medical ☐ Dental ☐ Vision

Reason for declining coverage

- ☐ Spousal / domestic partner group coverage
- ☐ Parental group coverage
- ☐ COBRA coverage
- ☐ Medicare
- ☐ Medicaid
- ☐ Retiree coverage
- ☐ Another group plan provided by my employer
- ☐ Insurance through another job
- ☐ Individual coverage - On Exchange
- ☐ Individual coverage - Off Exchange
- ☐ TRICARE Military coverage
- ☐ VA coverage
- ☐ I have no other coverage
- ☐ I do not want
- ☐ Other _____

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 dependent(s). ***Date (Month/Day/Year)***

X Employee signature:

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 appling for replace the coverage you have now? ☐ Yes ☐ No

Name of person	Carrier name	Name of person	Carrier name

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 an Aetna plan(s), coverage is provided by Aetna Life Insurance Company (referred to as "Aetna"). Vision insurance plans are underwritten by Aetna Life Insurance Company (Aetna). Certain claims administration services are provided by First American Administrators, Inc. and certain network administration services are provided through EyeMed Vision Care, LLC ("EyeMed").
2. I understand that: my employer's application will determine coverage and that there is no coverage unless and until both the eligible employee enrollment form and employer application have been accepted and approved by Aetna.
3. I understand and agree that: this enrollment 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 or 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 Request form, excluding drug and alcohol records and psychotherapy notes. 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. This authorization will remain valid no longer than 24 months. I understand that I am entitled, as is any authorized representative that I may designate, 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 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 a contest of enrollment in the plans described above.
4. The plan certificate of coverage will determine the rights and responsibilities of member(s). It 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® and Aetna Specialty Pharmacy®, all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, and Aetna Specialty Pharmacy, LLC, are subsidiaries 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 dentist or by the participating dentist or other provider as authorized by a referral from a participating primary care dentist.
7. This form is attached to and forms part of the policy and certificate, and may be used to contest the insurance. made by the insured relating to their insurability with respect to which such statement was made only if a copy.
8. The validity of individual coverage may be contested within the first two years during the insured's lifetime using written, signed statements has been furnished to the insured or their beneficiary. The policy is incontestable after two years other than non-payment of premiums.

Misrepresentation

9. 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.

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 from the date first eligible or 31 days of the qualifying life event (i.e., marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.) 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.

If you wish to receive documents online, please visit your secure member account at http://www.aetna.com/individuals-families/aetna-navigator.html.

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

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