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 the health information pages are not visible.

aetna®

Texas Employee Enrollment/Change Form
51 or more employees

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 B and F.**

Social Security Number

Company Name				
Effective Date	☐ New Hire ☐ Rehire/Reinstatement ☐ New Group Enrollment ☐ Late Enrollment ☐ Other ______________	☐ Change of Coverage ☐ Add Spouse/Domestic Partner ☐ Add Dependent Child ☐ Name Change ☐ Other ______________	☐ Employee Termination ☐ Remove Spouse/ Domestic Partner ☐ Remove Dependent Child ☐ Cancel Coverage	COBRA/State Continuation for: ☐ Employee ☐ Dependent Length of Continuation: ☐ 18 ☐ 36 ☐ Other _____ Original Qualifying Event Date __________________ Reason ______________________
Date of Hire				

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 – *Check one:*

☐ Aetna OAMC Plan: ______________________________

☐ Aetna HNOnly Plan: ______________________________

☐ Aetna Savings Plus Plan: ______________________________

☐ Aetna Whole Health EPO Plan: ______________________________

☐ Aetna EPO Plan: ______________________________

☐ Aetna PPO Plan: ______________________________

☐ Aetna Indemnity Plan: ______________________________

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

2. Dental - *To enroll, enter the plan number and name elected below.*

Standard Plan: Plan Number: __________ Plan Name: ______________________________ FOC Options: ☐ DMO® *or* ☐ PDN

Voluntary Plans: Plan Number: __________ Plan Name: ______________________________ FOC Options: ☐ DMO® *or* ☐ PDN

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

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

3. Life and Disability ☐ Basic Life ☐ Optional Dependent Life ☐ Short Term Disability ☐ Long 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.*

Member ID Number (if available)	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 ( ) -	No. of Hours Usually Worked Per Week	Number of Dependents (including Spouse/ Domestic Partner) enrolling for coverage
Salary **$** ☐ Hourly ☐ Weekly ☐ Monthly	Check One	☐ Full-Time ☐ 1099 ☐ Union ☐ Seasonal ☐ Part-Time ☐ Retiree ☐ COBRA ☐ Temporary	

continued on next page

Social Security Number

B. Employee Information *(Continued)*

Subscriber Primary Language (other than English) Primer Idioma del suscriptor (que no sea el Ingles) What is your primary Language? ¿Cuál es su primer idioma? ____________________	**Subscriber Disability** Do you have a disability which affects your ability to communicate or read? ☐ Yes ☐ No If Yes, please indicate the nature of your disability. ____________________

C. Individuals Covered - *List individuals for whom you are enrolling or adding/changing/removing coverage. Insert additional sheets if necessary. NOTE: Enter Domestic Partner ONLY if your employer has elected that coverage.*

NOTE FOR MEDICAL AND DENTAL 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. 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) / /	Incapacitated **N/A**	Coverage Election ☐ Medical ☐ Dental ☐ Life/Disability	Other Health Coverage **Yes** ☐	
Primary Office ID Number *(if applicable)*	Current Patient **Yes** ☐	Dental Office ID Number *(if applicable)*	Current Patient **Yes** ☐	

2	**(A)**dd **(C)**hange ____ **(R)**emove	☐ **Spouse** ☐ **Domestic Partner** **Name** (Last, First, M.I.)	Sex (M/F)	**Social Security Number**
Birthdate (MM/DD/YYYY) / /	Incapacitated **N/A**	Coverage Election ☐ Medical ☐ Dental ☐ Life	Other Health Coverage **Yes** ☐	
Primary Office ID Number *(if applicable)*	Current Patient **Yes** ☐	Dental Office ID Number *(if applicable)*	Current Patient **Yes** ☐	

3	**(A)**dd **(C)**hange ____ **(R)**emove	☐ **Child** ☐ **Stepchild** ☐ **Other** **Name** (Last, First, M.I.)	Sex (M/F)	**Social Security Number**
Birthdate (MM/DD/YYYY) / /	Incapacitated **Yes** ☐	Coverage Election ☐ Medical ☐ Dental ☐ Life	Other Health Coverage **Yes** ☐	
Primary Office ID Number *(if applicable)*	Current Patient **Yes** ☐	Dental Office ID Number *(if applicable)*	Current Patient **Yes** ☐	

4	**(A)**dd **(C)**hange ____ **(R)**emove	☐ **Child** ☐ **Stepchild** ☐ **Other** **Name** (Last, First, M.I.)	Sex (M/F)	**Social Security Number**
Birthdate (MM/DD/YYYY) / /	Incapacitated **Yes** ☐	Coverage Election ☐ Medical ☐ Dental ☐ Life	Other Health Coverage **Yes** ☐	
Primary Office ID Number *(if applicable)*	Current Patient **Yes** ☐	Dental Office ID Number *(if applicable)*	Current Patient **Yes** ☐	

5	**(A)**dd **(C)**hange ____ **(R)**emove	☐ **Child** ☐ **Stepchild** ☐ **Other** **Name** (Last, First, M.I.)	Sex (M/F)	**Social Security Number**
Birthdate (MM/DD/YYYY) / /	Incapacitated **Yes** ☐	Coverage Election ☐ Medical ☐ Dental ☐ Life	Other Health Coverage **Yes** ☐	
Primary Office ID Number *(if applicable)*	Current Patient **Yes** ☐	Dental Office ID Number *(if applicable)*	Current Patient **Yes** ☐	

continued on next page

Social Security Number

C. Individuals Covered *(Continued) List individuals for whom you are enrolling or adding/changing/removing coverage. Insert additional sheets if necessary.*

6	**(A)**dd **(C)**hange _____ **(R)**emove	☐ **Child** ☐ **Stepchild** ☐ **Other** **Name** (Last, First, M.I.)	Sex (M/F)	**Social Security Number**

Birthdate (MM/DD/YYYY) / /	Incapacitated **Yes** ☐	Coverage Election ☐ Medical ☐ Dental ☐ Life	Other Health Coverage **Yes** ☐

Primary Office ID Number *(if applicable)*	Current Patient **Yes** ☐	Dental Office ID Number *(if applicable)*	Current Patient **Yes** ☐

D. Dependent Information

List any dependent in Section **C** living at another address.

Name	**Address**

For Dependent Life: If age 19 and over and a full-time student, provide the following:

Child Name	**School Name**	**Expected Graduation Date**	**Number of Credit Hours**

E. 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**

F. Medicare Information

Name of Person	**Medicare Part A**	**Medicare Part B**	**Medicare Part D**	**Over Age 65**	**Disability**	**End-Stage Renal Disease Effective Date**
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

G. 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.*

☐ **Medical Coverage declined for:**
- ☐ Myself ☐ Child(ren)
- ☐ Spouse/Domestic Partner

☐ **Dental Coverage declined for:**
- ☐ Myself ☐ Child(ren)
- ☐ Spouse/Domestic Partner

Reason for declining coverage

- ☐ Spouse/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 or CHAMPVA
- ☐ Individual coverage – On or Off Exchange
- ☐ 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 or your dependent(s). **Employee Signature X**	***Date (Month/Day/Year)***

Social Security Number

H. Health Questionnaire must be completed when the employer group is:

- A virgin group with no group medical coverage;
- A newly formed business with no group medical coverage;
- Requesting life coverage above the Guarantee Issue amount or a Life Late Enrollee (enrolling more than 31 days after eligible).

Health History for Individuals and your Dependents. ***The following information is confidential and will not be seen by or given to your employer.***
- ALL of the questions must be answered by you or your dependents or the enrollment form will be returned.
- Incomplete enrollment forms may delay the effective date of your coverage.

List all individuals enrolling for coverage. **Name**	**Sex**	**Age**	**Height**	**Weight**	**Smoker**	**Currently Taking Prescription Medication(s)**
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No

Answer all questions.

1. Within the last 5 years has anyone applying for coverage consulted, received treatment, by a doctor, psychiatrist, psychologist, or other practitioner or been diagnosed with any of the following conditions or disorders? (Check all that apply.) ☐ Yes ☐ No

a. ☐ Diabetes
b. ☐ Infertility
c. ☐ Endocrine/Metabolic
d. ☐ Pancreas
e. ☐ Liver/Hepatitis
f. ☐ Immune System
g. ☐ Blood Disorder
h. ☐ Epilepsy/Seizure
i. ☐ Heart
j. ☐ Paralysis/Paresis
k. ☐ Tumor/Cyst/Growth
l. ☐ Systemic or Discoid Lupus
m. ☐ Lung or Respiratory
n. ☐ Alcohol or Drug Use
o. ☐ Kidney/Bladder/Urinary
p. ☐ Circulatory/Vascular
q. ☐ Digestive/Stomach/Intestinal
r. ☐ Central Nervous System
s. ☐ Pituitary/Adrenal/ Growth Disorder
t. ☐ Birth Defects/Congenital Abnormalities
u. ☐ Arthritis/Bone/Joint/Muscle/Prosthetic Device
v. ☐ Mental/Nervous/Emotional/Eating Disorder
w. ☐ Stroke/Brain/Neurological
x. ☐ Transplant: ☐ Recommended ☐ Pending ☐ Complete
y. ☐ Advised to have surgery or course of treatment not yet determined
z. ☐ Cancer: Type:____________________ Stage ______
☐ Surgery ☐ Chemo ☐ Radiation
aa. ☐ Using: ☐ Crutches ☐ Walker ☐ Wheelchair
bb. ☐ Other ____

2. Has anyone applying for coverage ever been diagnosed as having or been told by a medical doctor that they have AIDS, HIV or an ARC disorder? ☐ Yes ☐ No

3. Is any female currently pregnant? If so, provide due date ________________ Check applicable boxes: ☐ C section planned ☐ Multiple Births Expected (# _____) ☐ Complications: ☐ Past or ☐ Present ☐ Yes ☐ No

4. Has anyone applying for coverage incurred medical expenses in excess of $5,000 in the past 24 months? ☐ Yes ☐ No

5. Has anyone applying for coverage been prescribed medications in the past 12 months? ☐ Yes ☐ No

6. Does anyone applying for coverage have a known condition that requires on-going treatment? ☐ Yes ☐ No

7. Do you or your spouse/domestic partner use tobacco products? If so, check the applicable boxes: ☐ Yes ☐ No
☐ Employee: ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Chewing Tobacco
☐ Spouse/Domestic Partner: ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Chewing Tobacco

Provide details below to any boxes checked above. ***(If additional space is needed, attach a separate sheet and be sure to sign and date the sheet.)***

Ques. No.	**Name of Individual**	**Condition/Diagnosis/ Treatment**	**Date of Onset**	**Date Treatment Ended**	**Name of Prescription Medication(s)**	**Dosage**	**Still Taking Medication**
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

continued on next page

Social Security Number

Ques. No.	Name of Individual	Condition/Diagnosis/ Treatment	Date of Onset	Date Treatment Ended	Name of Prescription Medication(s)	Dosage	Still Taking Medication
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
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							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

If you are providing additional sheets, check here ☐ and insert the sheets before sealing this Enrollment form.

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Social Security Number

Conditions of Enrollment

On behalf of myself and the dependents listed on the reverse side, 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 HNOnly Plan: Aetna Health Inc.
   - Aetna Dental DMO: Aetna Dental Inc.
   - Life, disability, dental and all other health 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 and employer applications have been accepted by Aetna. Even if this enrollment form is accepted, any intentional misrepresentation of material fact may result in future claims being denied.

   For life and disability 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.
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 and substance abuse. 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.
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 injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any intentional misrepresentation of material fact or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

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 **Texas** 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, usually 25 hours per week, for this employer at the regular place of business.

If you have questions concerning the benefits and services that are provided by or excluded under this Agreement, please contact a Member Services representative at 1-800-323-9930 before signing this form.

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