

**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 pages 2 and 3 are not visible.**



# Arizona Group Business (2 - 99 Eligible Employees) Employee Enrollment/Change Form

Group Number
Member Aetna ID Number (if available)

Company Name		<b>INSTRUCTIONS:</b> 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. <b>If waiving coverage, please complete Sections B and I.</b>			
Effective Date	<input type="checkbox"/> New Hire <input type="checkbox"/> Rehire/Reinstatement <input type="checkbox"/> New Group Enrollment <input type="checkbox"/> Late Enrollment <input type="checkbox"/> Other _____	<input type="checkbox"/> Change of coverage <input type="checkbox"/> Add Spouse/Dependent Child <input type="checkbox"/> Name Change <input type="checkbox"/> Other _____	<input type="checkbox"/> Employee Termination <input type="checkbox"/> Remove Spouse/Dependent Child <input type="checkbox"/> Cancel Coverage	COBRA/State 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 _____ Original Qualifying Event Date _____	
Date of Hire					Qualifying Event _____

**A. Coverage Selection – Please print clearly, using black ink.**

Control/Group No.	Suffix	Account	Plan No.	Class Code	Control/Group No.	Suffix	Account	Plan No.	Control/Group No.	Suffix	Account	Plan No.		
<b>1. Medical - Check one.</b> <input type="checkbox"/> HMO 15/30/250d HMO+ (QPOS): <input type="checkbox"/> 10/20/250a <input type="checkbox"/> 15/30/250d <input type="checkbox"/> 20/40/500d CPOS: <input type="checkbox"/> 250 90/70 10/20 <input type="checkbox"/> 250 80/60 15/30 <input type="checkbox"/> 500 90/70 10/20 <input type="checkbox"/> 500 80/60 15/30 <input type="checkbox"/> 750 80/60 20/40 <input type="checkbox"/> 1000 80/60 25/50 <input type="checkbox"/> 1500 70/50 25/50 <input type="checkbox"/> 1500 100/50 15/30 <input type="checkbox"/> 2500 100/50 25/50 <input type="checkbox"/> 5000 100/50 25/50 PPO: <input type="checkbox"/> 250 80/60 10/20 <input type="checkbox"/> 500 90/70 10/20 <input type="checkbox"/> 500 80/60 15/30 <input type="checkbox"/> 500 80/50/50 20/40 <input type="checkbox"/> 750 80/60 20/40 <input type="checkbox"/> 1000 70/50 25/50 <input type="checkbox"/> 2000 70/50 25/50  <input type="checkbox"/> PPO Value <input type="checkbox"/> PPO Value Saver <input type="checkbox"/> PPO Value Limited <input type="checkbox"/> PPO HSA HDHP 2300 100/50 <input type="checkbox"/> CPOS HSA HDHP 2500 80/50 <input type="checkbox"/> PPO HSA HDHP 3000 80/50 <input type="checkbox"/> CPOS HRA HDHP 3000 80/50 <input type="checkbox"/> Indemnity 500 80% <input type="checkbox"/> Out of State PPO					<b>2. Dental - Check one.</b> <b>Standard Plans:</b> <input type="checkbox"/> Option 1 - DMO® <input type="checkbox"/> Option 2 - Freedom-of-Choice: <input type="checkbox"/> DMO® or <input type="checkbox"/> PPO <input type="checkbox"/> Option 3 - PPO Max 1500 <input type="checkbox"/> Option 4 - PPO Max 1000 <input type="checkbox"/> Option 5 - PPO 1500 (90th) <input type="checkbox"/> Option 6 - DMO® Plan 41 <input type="checkbox"/> Option 7 - DMO® Access <input type="checkbox"/> Option 8 - Aetna Dental Preventive Care <sup>SM</sup> PPO Max <input type="checkbox"/> Option 9 - PPO Max 2000 <input type="checkbox"/> Out of State PPO  <b>Voluntary Plans:</b> <input type="checkbox"/> Option V1 - DMO® <input type="checkbox"/> Option V2 - Freedom of Choice <input type="checkbox"/> DMO® or <input type="checkbox"/> PPO <input type="checkbox"/> Option V3 - PPO Max 1500 <input type="checkbox"/> Option V4 - DMO® Plan 41  Before today, were you covered under this employer's dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No					<b>3. Life and Disability</b> <input type="checkbox"/> Basic Life/AD&D Ultra™ <input type="checkbox"/> Optional Dependent Life <input type="checkbox"/> Life & Disability Packaged Plan  Beneficiary Designation - <b>Full Name</b> (First, Middle, Last) _____  Beneficiary Social Security Number _____  Relationship to Employee _____				

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

Social Security Number	Last Name, First Name, M.I.	Job Title	Home Telephone	Primary Language Spoken (Optional)	
Home Address		Apt. No.	City, State		ZIP Code
Work Address		City, State		ZIP Code	Work Telephone
Salary (Complete only if enrolling for Life or Disability) \$	<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	Number of Hours Worked Per Week	Check One <input type="checkbox"/> Full-Time <input type="checkbox"/> 1099 <input type="checkbox"/> Seasonal <input type="checkbox"/> Part-Time <input type="checkbox"/> Retiree <input type="checkbox"/> Temporary		No. of Dependents Excluding Self

**C. Other Insurance**

Does anyone enrolling on this enrollment form have current or prior coverage?  Yes  No

Proof of coverage must accompany this enrollment form for pre-existing condition credit and if an employee is waiving coverage. Acceptable forms of proof are:

1. Certificate of Creditable Coverage from prior carrier, or
2. Copy of ID card or most recent payroll stub showing medical coverage deduction, or
3. Copy of most recent medical premium bill from prior carrier.

Failure to provide Proof of Prior Coverage may subject you or a family member to the full pre-existing conditions limitation with no credit for prior coverage. You may request a Certificate of Creditable Coverage from your prior carrier.

Name of Covered Individual	Carrier Name	Group Number	Start Date	Termination Date	Health	Dental
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**D. Individuals Covered - List individuals for whom you are enrolling or adding/changing/removing coverage. Insert additional sheets if necessary.**

1. (A)dd (C)hange (R)emove _____		Employee Name (Last, First, M.I.)				Sex (M/F)	Social Security Number		Birthdate (MM/DD/YYYY)	
Height (ft, in)	Weight (lbs)	Status	Coverage Election	Other Dental Coverage	Prior Dental Coverage	Primary Office ID # (If applicable)	Current Patient	Dental Office ID # (If applicable)	Current Patient	
		<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated	<input type="checkbox"/> Medical <input type="checkbox"/> Life/Dis <input type="checkbox"/> Dental	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>		Yes <input type="checkbox"/>		Yes <input type="checkbox"/>	
2. (A)dd (C)hange (R)emove _____		Spouse Name (Last, First, M.I.)				Sex (M/F)	Social Security Number		Birthdate (MM/DD/YYYY)	
Height (ft, in)	Weight (lbs)	Status	Coverage Election	Other Dental Coverage	Prior Dental Coverage	Primary Office ID # (If applicable)	Current Patient	Dental Office ID # (If applicable)	Current Patient	
		<input type="checkbox"/> Different last name	<input type="checkbox"/> Medical <input type="checkbox"/> Life <input type="checkbox"/> Dental	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>		Yes <input type="checkbox"/>		Yes <input type="checkbox"/>	
3. (A)dd (C)hange (R)emove _____		Child Name (Last, First, M.I.)				Sex (M/F)	Social Security Number		Birthdate (MM/DD/YYYY)	
Height (ft, in)	Weight (lbs)	Status	Coverage Election	Other Dental Coverage	Prior Dental Coverage	Primary Office ID # (If applicable)	Current Patient	Dental Office ID # (If applicable)	Current Patient	
		<input type="checkbox"/> Different last name <input type="checkbox"/> Lives at another address <input type="checkbox"/> Full-time Student (+19) <input type="checkbox"/> Disabled (+19)	<input type="checkbox"/> Medical <input type="checkbox"/> Life <input type="checkbox"/> Dental	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>		Yes <input type="checkbox"/>		Yes <input type="checkbox"/>	
4. (A)dd (C)hange (R)emove _____		Child Name (Last, First, M.I.)				Sex (M/F)	Social Security Number		Birthdate (MM/DD/YYYY)	
Height (ft, in)	Weight (lbs)	Status	Coverage Election	Other Dental Coverage	Prior Dental Coverage	Primary Office ID # (If applicable)	Current Patient	Dental Office ID # (If applicable)	Current Patient	
		<input type="checkbox"/> Different last name <input type="checkbox"/> Lives at another address <input type="checkbox"/> Full-time Student (+19) <input type="checkbox"/> Disabled (+19)	<input type="checkbox"/> Medical <input type="checkbox"/> Life <input type="checkbox"/> Dental	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>		Yes <input type="checkbox"/>		Yes <input type="checkbox"/>	
5. (A)dd (C)hange (R)emove _____		Child Name (Last, First, M.I.)				Sex (M/F)	Social Security Number		Birthdate (MM/DD/YYYY)	
Height (ft, in)	Weight (lbs)	Status	Coverage Election	Other Dental Coverage	Prior Dental Coverage	Primary Office ID # (If applicable)	Current Patient	Dental Office ID # (If applicable)	Current Patient	
		<input type="checkbox"/> Different last name <input type="checkbox"/> Lives at another address <input type="checkbox"/> Full-time Student (+19) <input type="checkbox"/> Disabled (+19)	<input type="checkbox"/> Medical <input type="checkbox"/> Life <input type="checkbox"/> Dental	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>		Yes <input type="checkbox"/>		Yes <input type="checkbox"/>	
6. (A)dd (C)hange (R)emove _____		Child Name (Last, First, M.I.)				Sex (M/F)	Social Security Number		Birthdate (MM/DD/YYYY)	
Height (ft, in)	Weight (lbs)	Status	Coverage Election	Other Dental Coverage	Prior Dental Coverage	Primary Office ID # (If applicable)	Current Patient	Dental Office ID # (If applicable)	Current Patient	
		<input type="checkbox"/> Different last name <input type="checkbox"/> Lives at another address <input type="checkbox"/> Full-time Student (+19) <input type="checkbox"/> Disabled (+19)	<input type="checkbox"/> Medical <input type="checkbox"/> Life <input type="checkbox"/> Dental	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>		Yes <input type="checkbox"/>		Yes <input type="checkbox"/>	

**E. Race/Ethnicity - Optional** (This information is designed for the purpose of data collection and will not be used for determining eligibility, rating or claim payment.)

Employee	<input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02 <input type="checkbox"/> Hispanic or Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____	Child	<input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02 <input type="checkbox"/> Hispanic or Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____
Spouse/Domestic Partner	<input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02 <input type="checkbox"/> Hispanic or Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____	Child	<input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02 <input type="checkbox"/> Hispanic or Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____
Child	<input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02 <input type="checkbox"/> Hispanic or Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____	Child	<input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02 <input type="checkbox"/> Hispanic or Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____

**F. Dependent Information**

List any dependent in Section D living at another address.	Name:	Reason:	Address:
If any dependent's last name differs from yours, explain.	Name:	Reason:	
If age 19+ and a full-time student, provide the following:			
Child Name	School Name	Expected Graduation Date	Number of Credit Hours

**G. Medicare Information**

Name of Person	Medicare Part A	Medicare Part B	Medicare Part D	Over Age 65	Disability	End-Stage Renal Disease Effective Date
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**H. Health Questionnaire for Groups Enrolling 2 - 25 Employees (and employees of groups enrolling 26-50 Employees who are requesting Basic Life benefits greater than the Guaranteed Issue Level) -- Please complete the Uniform Employee Health Status Questionnaire, which can be found at [www.id.state.az.us/consumerbusiness.html#health](http://www.id.state.az.us/consumerbusiness.html#health).**

**I. 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.**

<p>1. Medical Coverage Declined for:</p> <input type="checkbox"/> Myself <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Dependents	<p>Reason for Declining Coverage (If applicable, please attach front/back of your health coverage ID card.):</p> <input type="checkbox"/> Covered by spouse/domestic partner's group coverage - Carrier Name and ID: _____ <input type="checkbox"/> Enrolled in other Insurance Carrier Plans - Carrier Name and ID _____ <input type="checkbox"/> Spouse/Domestic Partner covered by employer's group medical coverage <input type="checkbox"/> Spouse/Domestic Partner covered by employer's group dental coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Covered by TRICARE or CHAMPVA <input type="checkbox"/> AHCCCS <input type="checkbox"/> Indian Health Services <input type="checkbox"/> Other (Explain) _____
<p>2. Dental Coverage Declined for:</p> <input type="checkbox"/> Myself <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Dependents	
<p>3. Coverage Declined for:</p> <input type="checkbox"/> Life/Life & Disability Pkg Plan <input type="checkbox"/> Optional Dependent Life	
<p>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 myself and/or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage. Pre-existing conditions, when enrolled in other than an HMO plan, may not be covered for twelve months.</p>	
<p><i>Please sign here ONLY if you are declining coverage for yourself or dependent(s).</i></p>	
<p><b>X</b> Employee Signature</p>	<p>Date (Month/Day/Year)</p>

**Conditions of Enrollment**

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

- I acknowledge that by enrolling in the following plans, coverage is provided by the following entities (collectively referred to as "Aetna"):
  - Aetna HMO and Aetna POS plans: Aetna Health Inc., Aetna Health Insurance Company and/or Aetna Life Insurance Company.
  - Aetna PPO plans: Aetna Life Insurance Company.
  - Life, Accidental Death & Dismemberment, disability, dental (except DMO<sup>®</sup>) and all other coverages: Aetna Life Insurance Company. DMO<sup>®</sup> dental coverage is provided by Aetna Health Inc.
- I understand and agree that my employer's enrollment form will determine coverage and that there is no coverage unless and until both the eligible employee enrollment form 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.
 

**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.
- 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 or pharmacy database benefit managers to give to 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 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. I understand that this authorization is provided under state law, and that it is not an "authorization" within the meaning of the federal Health Insurance Portability and Accountability Act.

Conditions of Enrollment (Continued)

This authorization is valid for term of the coverage and so long thereafter as allowed by law. 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.

4. Authorizations signed for the purpose of collecting information in connection with this enrollment form for an insurance policy, a policy reinstatement or a request for changes in policy benefits shall remain valid for thirty (30) months from the date signed. Authorization signed for the purpose of collecting information in connection with a claim for benefits shall remain valid for the term of this coverage or for so long as allowed by law. The information, as well as other personal or privileged information, subsequently collected by the insurance institution or agent may, in certain circumstances, be disclosed to third parties without authorization. A right of access and correction exists with respect to all personal information collected. Further disclosures required by Arizona law will be furnished to the policyholder upon request. Personal information may be collected from persons other than the individual or individuals proposed for coverage.
5. 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.
6. 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.
7. I understand and agree that, with certain exceptions described in the plan documents, HMO and DMO<sup>®</sup> 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.
8. I understand and agree that, as described in the plan documents and when enrolled for medical and disability coverage in other than an HMO plan, any pre-existing conditions for my spouse, dependents or myself may not be covered for 12 months.

I represent that all information supplied in this form is true and complete. I have read and agree to the Conditions of Enrollment on this **Arizona** Group Business (2 - 99 Eligible Employees) 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 at the regular place of business.

<b>Employee Signature</b> X	<b>Date (Month/Day/Year)</b>
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