

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.



Ohio Small Group Business (2 - 50 Eligible Employees) Employee Enrollment/Change Form

Group Number
Member Aetna ID Number (if available)

Company Name		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 G.			
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 _____ 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.
1. Medical - Check applicable boxes. <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) Check one: <input type="checkbox"/> Choice® POS (Open Access) - Plan Option _____ <input type="checkbox"/> Managed Choice® POS (Open Access) - Plan Option _____ <input type="checkbox"/> Open Choice® PPO - Plan Option _____ <input type="checkbox"/> Indemnity <input type="checkbox"/> Other _____					2. Dental - Check applicable boxes. <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) Check one: Standard Plans <input type="checkbox"/> Option 1: DMO® Access <input type="checkbox"/> Option 2: Freedom-of-Choice PPO Max 100/70/40 <input type="checkbox"/> DMO® or <input type="checkbox"/> PPO <input type="checkbox"/> Option 3: PPO Max 1000 <input type="checkbox"/> Option 4: PPO Max 1500 <input type="checkbox"/> Option 5: Freedom-of-Choice PPO 100/70/40 <input type="checkbox"/> DMO® or <input type="checkbox"/> PPO <input type="checkbox"/> Option 6: Active PPO (90th) <input type="checkbox"/> Option 7: PPO 1500 (90th) <input type="checkbox"/> Option 8: Aetna Dental Preventive Care SM PPO Max <input type="checkbox"/> Out-of-State PPO Voluntary Plans <input type="checkbox"/> Option V1: DMO® Access <input type="checkbox"/> Option V2: Freedom-of-Choice <input type="checkbox"/> DMO® or <input type="checkbox"/> PPO <input type="checkbox"/> Option V3: PPO Max <input type="checkbox"/> Option V4: Aetna Dental Preventive Care SM PPO Max <input type="checkbox"/> Out-of-State PPO Before today, were you covered under this employer's dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No					3. Life & Disability - Check applicable boxes. <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) Check if applicable: <input type="checkbox"/> Basic Life/AD&D Ultra™ <input type="checkbox"/> Optional Dependent Life <input type="checkbox"/> Short Term Disability <input type="checkbox"/> Life & Disability Packaged Plan Beneficiary Designation - Full Name (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 (required) \$	<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	No. of Hours Worked Per Week	Check One	<input type="checkbox"/> Full-time <input type="checkbox"/> 1099 <input type="checkbox"/> Part-time <input type="checkbox"/> Retired <input type="checkbox"/> Seasonal <input type="checkbox"/> Temporary	No. of Dependents Including Spouse

C. Individuals Covered - List individuals for whom you are enrolling or adding/changing/removing coverage. Insert additional sheets if necessary. If you are providing additional sheets, check here and insert the sheets before sealing this enrollment form.

Name (Last, First, M.I.)	Sex M/F	Social Security Number	Birthdate MM / DD / YYYY	Relationship	Height (ft, in)	Weight (lbs)	Status	Coverage Election	PCP Provider ID#
Employee 1.							<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"/> Dental <input type="checkbox"/> Life/Dis	
2.				<input type="checkbox"/> Spouse <input type="checkbox"/> Other _____			<input type="checkbox"/> Different last name	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	
Child 3.				<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____			<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"/> Dental <input type="checkbox"/> Life	
Child 4.				<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____			<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"/> Dental <input type="checkbox"/> Life	

D. Dependent Information

List any dependent in Section C 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

E. Medicare Information

Name of Person	Medicare Part A	Medicare Part B	Medicare Part D	Over Age 65	Disability	End-Stage Renal Disease Eff 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	

F. 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

G. Declination/Waiver of Coverage - Check all that apply.

I understand I am eligible to apply for this coverage through my employer; however, I am waiving coverage as noted below.

<input type="checkbox"/> Employee	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Life	<input type="checkbox"/> Disability	Reason for declining coverage (If applicable attach front/back of your health ID card): <input type="checkbox"/> Covered by spouse's group coverage - Carrier Name: _____ <input type="checkbox"/> Enrolled in other insurance - Carrier Name: _____ <input type="checkbox"/> Spouse covered by employer's group insurance <input type="checkbox"/> Medicare <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> Military <input type="checkbox"/> Individual <input type="checkbox"/> Do not want <input type="checkbox"/> Other _____
<input type="checkbox"/> Spouse	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Life		
<input type="checkbox"/> Child	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Life		

I certify I have been given the right to apply for this coverage, however, I am waiving coverage as noted above. 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 this plan, may not be covered for twelve months.

Please sign here ONLY if you are declining coverage for yourself and/or dependent(s).	Date (Month/Day/Year)
<input checked="" type="checkbox"/> Employee Signature	

H. 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	Child	<input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02
1. <input type="checkbox"/> Hispanic or Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____		3. <input type="checkbox"/> Hispanic or Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____	
Spouse	<input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02	Child	<input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02
2. <input type="checkbox"/> Hispanic or Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____		4. <input type="checkbox"/> Hispanic or Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____	

I. Health Questionnaire for Groups Enrolling 2 - 9 Employees

Health History for Individuals and Their 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 and your dependents or the enrollment form will be returned.
- Incomplete enrollment forms may delay the effective date of your coverage.

In the past five (5) years, has any person listed on the enrollment form seen a health care provider(s), had treatment recommended, received treatment, including prescription medications or been hospitalized for any of the following conditions listed below?

	Yes	No
1. Heart attack, heart murmur, stroke, chest pain, high blood pressure, anemia, varicose veins or other disorders of the heart, blood, blood vessels or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>
2. Ulcer, colitis, gallstones or any other disorder of the stomach, intestines, rectum, pancreas, liver or Hepatitis B/C?	<input type="checkbox"/>	<input type="checkbox"/>
3. Cancer, cyst or tumor?	<input type="checkbox"/>	<input type="checkbox"/>
4. Disorders of the kidneys, adrenal glands, thyroid gland, urinary system, male or female organs, infertility, menstrual dysfunction or sexually transmitted disease (except AIDS/ARC)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Asthma, emphysema, tuberculosis or any other disorders of the lungs or respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>
6. Migraines, fainting spells, epilepsy, mental or nervous conditions, depression, paralysis or any disorder of the brain or nervous system? If epileptic, date of last seizure: ____/____/____ (month/day/year)	<input type="checkbox"/>	<input type="checkbox"/>
7. Lupus, arthritis, back trouble or any other disorder of the joints, muscles or bones, including prosthetic device or implants?	<input type="checkbox"/>	<input type="checkbox"/>
8. Any physical deformity, defect or congenital problem?	<input type="checkbox"/>	<input type="checkbox"/>
9. Has any person to be covered had or has been told they have an immune disorder, AIDS, or AIDS-Related Complex?	<input type="checkbox"/>	<input type="checkbox"/>
10. Has any person been treated for alcoholism, other drug or substance abuse, including use of any illegal or controlled drugs, or been advised to seek treatment for the same?	<input type="checkbox"/>	<input type="checkbox"/>

continued on next page

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS IN SECTION I, YOU MUST COMPLETE SECTION K ON THE FOLLOWING PAGE.

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

I. Health Questionnaire for Groups Enrolling 2 - 9 Employees (continued)

	Yes	No
11. Has any person been diagnosed with diabetes? If Yes, list date of diagnosis: ____/____/____ (month/day/year) Insulin dependent? _____ Non-insulin dependent? _____	<input type="checkbox"/>	<input type="checkbox"/>
12. a. Is any female to be covered currently pregnant? If Yes, list due date: ____/____/____ (month/day/year)	<input type="checkbox"/>	<input type="checkbox"/>
b. Have there been any complications thus far?	<input type="checkbox"/>	<input type="checkbox"/>
c. Are multiple births expected?	<input type="checkbox"/>	<input type="checkbox"/>
d. If you are a male listed on this enrollment form, are you expecting a child with anyone, even if the mother is not listed on this enrollment form?	<input type="checkbox"/>	<input type="checkbox"/>
13. Has any person taken any prescribed medications in the past 12 months? If Yes, list below.	<input type="checkbox"/>	<input type="checkbox"/>
14. Has any person had an abnormal physical exam or been advised to undergo further testing, surgery or treatment?	<input type="checkbox"/>	<input type="checkbox"/>
15. Has any person been a patient in a hospital, clinic, surgical center, sanatorium or medical facility as an outpatient or inpatient (excluding childbirth)?	<input type="checkbox"/>	<input type="checkbox"/>
16. Does anyone named on this enrollment form use tobacco products, including cigarettes, pipe, cigar, or chewing tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, check applicable boxes: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse		
17. Has any person had any medical condition or symptom not listed on this enrollment form?	<input type="checkbox"/>	<input type="checkbox"/>

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS IN SECTION I, YOU MUST COMPLETE SECTION K BELOW.

J. Health Questionnaire for Groups Enrolling 10 - 50 Eligible Employees

Health History for Individuals and Their 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 and your dependents or the enrollment form will be returned.
- Incomplete enrollment forms may delay the effective date of your coverage.

1. Within the last 24 months 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
<i>If a condition is not noted, please list it below in Section K.</i>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Diabetes <input type="checkbox"/> Paralysis/Paresis <input type="checkbox"/> Pituitary/Adrenal/Growth Disorder <input type="checkbox"/> Infertility <input type="checkbox"/> Tumor/Cyst/Growth <input type="checkbox"/> Arthritis/Bone/Joint/Muscle/Prosthetic Device <input type="checkbox"/> Endocrine <input type="checkbox"/> Systemic or Lupus <input type="checkbox"/> Mental/Nervous/Emotional/Eating <input type="checkbox"/> Pancreas <input type="checkbox"/> Lung or Respiratory <input type="checkbox"/> Stroke/Brain/Neurological/Central Nervous System <input type="checkbox"/> Liver/Hepatitis <input type="checkbox"/> Alcohol or Drug Use <input type="checkbox"/> Transplant (recommended, pending or complete) <input type="checkbox"/> Immune System <input type="checkbox"/> Kidney/Bladder/Urinary <input type="checkbox"/> Advised to have surgery or treatment is needed or pending <input type="checkbox"/> Cancer or Blood <input type="checkbox"/> Heart/Circulatory/Vascular <input type="checkbox"/> Had medical claims in excess of \$5,000 <input type="checkbox"/> Epilepsy/Seizure <input type="checkbox"/> Digestive/Stomach/Intestinal <input type="checkbox"/> Currently pregnant – due date: ____/____/____ (month/day/year) <input type="checkbox"/> Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) or tested positive for HIV		
2. Has anyone applying for coverage been prescribed medications in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does anyone applying for coverage have a known condition that requires on-going treatment?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you or your spouse use tobacco products, including cigarettes, pipe, cigar, or chewing tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, check applicable boxes: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse		

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS IN SECTION J, YOU MUST COMPLETE SECTION K BELOW.

K. Health Questionnaire - Details for "Yes" Responses in Sections I and J.

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS IN SECTIONS I AND J, YOU MUST COMPLETE THE FOLLOWING.

Please provide us with FULL DETAILS for each "Yes" answer to any condition(s) checked in Sections I and J. **In addition,** please give details below of last doctor visit and/or physical examination for ALL family members listed regardless of the date or reason. *(Insert additional sheets if necessary.)*

Question Number	Name of Individual	Condition/Diagnosis	Date of Onset	Date Treatment Ended	Medication Prescribed	Dosage	Still Taking Medication
							<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

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

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 Choice® POS (Open Access) and Aetna Open Access HMO: Aetna Health Insurance Company and/or Aetna Health Inc.
 - Aetna Open Choice® PPO: Aetna Life Insurance Company
 - Life, Accidental Death & Dismemberment, 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 this Enrollment/Change Form and the employer application have been accepted by Aetna. Even if this Enrollment/Change Form is accepted, any intentional and material misstatements or omissions that amount to fraud may result in future claims being denied and my coverage under the policy being rescinded or reevaluated, as of the effective date, for eligibility and rating purposes except as otherwise provided by law.

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") including pharmacies or pharmacy database benefit managers to give to Aetna or its agent information concerning the medical history, services or treatment provided to anyone listed on this enrollment 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 and competent adult dependents, and I have obtained their consent to those terms. Authorizations signed for the purpose of collecting information in connection with this application for an insurance policy, a policy reinstatement or a request for a change in policy benefits shall remain valid for thirty (30) months from the date it is signed. Authorizations 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. 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.
7. I understand and agree that, as described in the plan documents, when enrolled for medical coverage other than an HMO plan, any pre-existing conditions for my spouse, dependents or myself may not be covered for 12 months.

Misrepresentation

8. Any person who knowingly and with intent to defraud any insurance company or other person files an enrollment form 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.

I represent that all information supplied in this form is true and complete. I have read and agree to the Conditions of Enrollment, Authorizations and Misrepresentation on this Ohio Small Group Business (2-50 Eligible Employees) Employee Enrollment/Change Form. I understand that, in the event I fail to sign this form within 31 days of my eligibility date 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 at least 25 hours per week for this employer at the regular place of business.

<i>Employee Signature</i>	<i>Employee E-mail Address (optional)</i>	<i>Date (Month/Day/Year)</i>
X		