Alaska Small Group Employee Enrollment/Change Form

Aetna Life Insurance Company

Whether you are enrolling or declining coverage, you must sign Page 3 or Page 4 of the application.

INSTRUCTIONS: You 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 F.** Please use only black ink to complete this form.

Group number
Aetna member ID number (if available)

Company name			
Effective date **Date of hire**	☐ 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 date _____ ☐ Remove spouse ☐ Remove domestic partner ☐ Remove dependent child ☐ Cancel coverage ☐ Other _____
☐ **COBRA** 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. Please print clearly.*

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/cell telephone ( ) -	Work telephone ( ) -	Primary language spoken (optional)	Number of dependents, including spouse or domestic partner, enrolling for medical coverage	
Salary $ _____	☐ Hourly ☐ Weekly ☐ Monthly	Number of hours worked a week	Check one: ☐ Full time ☐ Part time ☐ 1099 ☐ Retiree ☐ Seasonal ☐ Temporary ☐ COBRA ☐ Union	
Employee email				

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

Control/Group number	**Suffix**	**Account**	**Plan number**

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

Non-voluntary plans – Plan number _____ Plan name _____

Voluntary plans – Plan number _____ Plan name _____

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

Aetna Life Insurance Company underwrites Aetna dental plans.

C. Individuals covered – ***List individuals for whom you are enrolling or adding, changing or removing coverage. Add more sheets if needed.***

1	☐ Add ☐ Change ☐ Remove	**Employee name** (Last, first, middle initial)	Sex (M/F)
Birthdate (MM/DD/YYYY) / /	Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally separated	Choosing coverage for: ☐ Dental	

2	☐ Add ☐ Change ☐ Remove	**Name** (Last, first, middle initial) ☐ **Spouse** ☐ **Domestic partner**	Sex (M/F)	Social Security number
Birthdate (MM/DD/YYYY) / /	Choosing coverage for: ☐ Dental			

3	☐ Add ☐ Change ☐ Remove	**Name** (Last, first, middle initial) ☐ **Child** ☐ **Stepchild** ☐ **Other** _____	Sex (M/F)	Social Security number
Birthdate (MM/DD/YYYY) / /	Incapacitated ☐ Yes ☐ No	Choosing coverage for: ☐ Dental		

4	☐ Add ☐ Change ☐ Remove	**Name** (Last, first, middle initial) ☐ **Child** ☐ **Stepchild** ☐ **Other** _____	Sex (M/F)	Social Security number
Birthdate (MM/DD/YYYY) / /	Incapacitated ☐ Yes ☐ No	Choosing coverage for: ☐ Dental		

5	☐ Add ☐ Change ☐ Remove	**Name** (Last, first, middle initial) ☐ **Child** ☐ **Stepchild** ☐ **Other** _____	Sex (M/F)	Social Security number
Birthdate (MM/DD/YYYY) / /	Incapacitated ☐ Yes ☐ No	Choosing coverage for: ☐ Dental		

6	☐ Add ☐ Change ☐ Remove	**Name** (Last, first, middle initial) ☐ **Child** ☐ **Stepchild** ☐ **Other** _____	Sex (M/F)	Social Security number
Birthdate (MM/DD/YYYY) / /	Incapacitated ☐ Yes ☐ No	Choosing coverage for: ☐ Dental		

D. Dependent information

List any dependent in Section **C** with a different last name or living at another address.

Name	Address

E. Coordination of benefits

Will you have other insurance at the same time as this coverage? ☐ Yes ☐ No

If **yes**, will the Aetna coverage you're applying for replace the coverage you have now? ☐ Yes ☐ No

Name of person	Carrier name	Name of person	Carrier name

F. Declining coverage – *Check all that apply.*

I understand I am eligible to apply for this coverage through my employer. However, I am declining the coverage I checked below:

☐ Employee:	☐ Dental	**Reason for declining coverage** ☐ Parental group coverage ☐ Spouse / domestic partner group coverage ☐ Medicare ☐ Medicaid ☐ Retiree coverage ☐ COBRA coverage ☐ Insurance through another job ☐ TRICARE / Military coverage ☐ Individual coverage – On Exchange ☐ Individual coverage – Off Exchange ☐ Another group plan provided by my employer ☐ Do not want ☐ Other _____
☐ Spouse / domestic partner:	☐ Dental	
☐ Children:	☐ Dental	

I certify I have been given the right to apply for this coverage. However, I am declining coverage as noted above. 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 dependents.	***Date (Month/Day/Year)***
☐ I am declining coverage. **Employee signature:** **X**	
Please PRINT employee name:	

Conditions of enrollment

I understand that the following legal entities underwrite the plans I apply for:

- Aetna Life Insurance Company underwrites Aetna dental plans.

1. My employer's application determines coverage. I don't have coverage until Aetna approves my employee enrollment form and the employer application. Even if Aetna approves the employer application, any misstatements or omissions may result in denial of future claims. Aetna may rescind or reevaluate my coverage under the policy, as of the effective date, for eligibility and rating purposes. If Aetna voids or rescinds coverage, I may be entitled to a refund of any paid premiums from the effective date of coverage. Aetna will give at least 30 days advance written notice to any covered person affected by the proposed rescission. If I elect to receive electronic notifications, I will receive this notice in an electronic (email) format.
2. To support the coverages listed on this enrollment form, Aetna may need information about medical history, services or treatment provided to anyone listed on this form. This may include information about mental health, substance use disorder and HIV / AIDS. I authorize that the following entities can provide this information to Aetna or its agents:
   - Physicians
   - Other healthcare professionals
   - Hospitals
   - Other healthcare organizations ("providers"), including
     - Pharmacies
     - Pharmacy database benefit managers

Continued on next page

Conditions of enrollment *(Continued)*

3. I authorize Aetna to use and disclose such information to:
   - Affiliates
   - Providers
   - Other insurers
   - Third party administration
   - Vendors
   - Consultants
   - Governmental authorities with jurisdiction when necessary for:
     - Care or treatment
     - Payment for services
     - Operation of my health plan
     - Conduct related activities
4. I discussed the terms of this authorization with my competent adult dependents. They agreed to these terms. This authorization is valid for 24 months from the signature date. This authorization is voluntary. But if I don't sign this form, my ability to enroll in the plan may be affected. I have the right to revoke this authorization in writing to Aetna at any time. I can't revoke authorization for information already used or disclosed before I revoked my authorization. I am entitled to receive a copy of this authorization upon request. A photocopy is as valid as the original.
   - The Group Agreement / Group Policy determines the rights and responsibilities of members and will govern in the event they conflict with any:
     - Benefits comparison
     - Summary
     - Other description of the plan
   - I understand and agree that, with the exception of members of the CVS Health family of companies (which includes CVS Pharmacy, CVS Caremark Mail Service Pharmacy**,** MinuteClinic and CVS Specialty Infusion Services)**,** all other participating providers and vendors are independent contractors and are neither agents nor employees of Aetna or its affiliates. We cannot guarantee the availability of any particular provider outside of our corporate family and the providers in our network may change. We also do not guarantee any results or outcome of a health or dental care service. Notice of any change shall be provided in accordance with applicable state law.
5. I authorize the substitution of generic pharmaceuticals for the brand-name products, as provided by law, for prescriptions filled under any pharmacy benefit.

To the best of my knowledge, 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 statement on this Employee Enrollment / Change Form.

I understand that if I do not sign this form within 31 days or Aetna does not receive the request within a reasonable time, my eligibility may be affected.

I am employed by the employer shown on page 1. I am working full time or at least 30 hours a week (or 20 hours a week if my employer extends coverage) 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 required for coverage.

To receive documents online, please visit your secure member account at aetna.com.

Misrepresentation: 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 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.

Please sign here ONLY if you are enrolling in coverage for yourself and / or dependents. ***Employee signature (required)***		***Date (Month/Day/Year)***