New York Small Group Business (2 – 50 Eligible Employees)
Employee Enrollment/Change Form

☐ **Aetna Life Insurance Company**
151 Farmington Avenue
Hartford, CT 06156

☐ **Aetna Health Inc.**
1425 Union Meeting Road
Blue Bell, PA 19422

☐ **Aetna Health Insurance Company of New York**
333 Earle Ovington Blvd., Suite 104
Uniondale, NY 11553

Life, Accidental Death & Dismemberment, Aetna EPO plans, Aetna Indemnity, and Aetna Managed Choice Plan PPO are provided by Aetna Life Insurance Company. Aetna Primary Care Plan HMO, Aetna QPOS, and Aetna NYC Community Plan℠ are provided by Aetna Health Inc. and Aetna Health Insurance Company of New York. DMO® and PPO dental plans are provided by Aetna Life Insurance Company.

Member Aetna ID Number (if available)

Employer 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 D.**

Effective Date

Date of Hire

☐ New Hire
☐ Rehire/Reinstatement
☐ New Group Enrollment
☐ Late Enrollment
☐ Other _____

☐ Change of Coverage
☐ Add Spouse/Domestic Partner/Dependent Child
☐ Name Change
☐ Other _____

☐ Employee Termination
☐ Remove Spouse/Domestic Partner/Dependent Child
☐ Cancel Coverage

COBRA/State Continuation for:
☐ Employee ☐ Dependent
Length of Continuation:
☐ 18 ☐ 36 ☐ Other _____
Original Qualifying Event Date
_____
Reason _____

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

Control/Group No.	Suffix	Account	Plan No.

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1. Medical
Open Access Elect Choice® (OA EPO) Plan Option: _____
Open Access Managed Choice® (OA MC) Plan Option: _____
Open Access Elect Choice® (OA EPO) HSA Compatible Plan Option: _____
Open Access Managed Choice® (OA MC) HSA Compatible Plan Option: _____
NYC Community Plan℠ Plan Option: _____
Indemnity Plan Option: _____

2. Dental
Standard Plans:
Option: _____
Options 3 & 8: DMO® ☐ *or* PPO ☐
Out-of-State: _____
Voluntary Plans:
Option: _____
Option 3: DMO® ☐ *or* PPO ☐
Out-of-State: _____
Before today, were you covered under this employer's dental plan? ☐ Yes ☐ No

3. Life and Disability
☐ Basic Life/AD&D Ultra™
☐ Optional Dependent Life
☐ 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

No. of Hours Worked Per Week	Check One	Marital Status	No. of Dependents Including Spouse/Domestic Partner
	☐ Full-Time ☐ Part-Time	☐ Married ☐ Single	

C. Individuals Covered - *List individuals for whom you are enrolling or adding/changing/removing coverage. Insert additional sheets if necessary. Height and weight information needed for Life Insurance applicants only.*

Name (Last, First, M.I.)	Sex M/F	Social Security Number	Birthdate (MM/DD/YYYY)	Coverage Election	Other Health Coverage	Other Dental Coverage	Prior Dental Coverage	Student Age 19 or Older	Out of Area	Primary Office ID Number (if applicable)	Current Patient	Dental Office ID Number (if applicable)	Current Patient
Employee 1.				☐ Medical ☐ Dental ☐ Life/Dis	Yes ☐	Yes ☐	Yes ☐	Yes N/A	Yes N/A		Yes ☐		Yes ☐
Spouse/Domestic Partner 2.				☐ Medical ☐ Dental ☐ Life	☐	☐	☐	N/A	N/A		☐		☐
Child 3.				☐ Medical ☐ Dental ☐ Life	☐	☐	☐	☐	☐		☐		☐
Child 4.				☐ Medical ☐ Dental ☐ Life	☐	☐	☐	☐	☐		☐		☐

D. 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.*

1. Medical Coverage Declined for:
☐ Myself ☐ Spouse/Domestic Partner ☐ Dependents

2. Dental Coverage Declined for:
☐ Myself ☐ Spouse/Domestic Partner ☐ Dependents

Reason for Declining Coverage *(If applicable, please attach front/back of your health coverage ID card.)*:
☐ Covered by spouse/domestic partner's group coverage - Carrier Name and ID _____
☐ Enrolled in other Insurance Carrier Plans - Carrier Name and ID _____
☐ Medicare ☐ Covered by TRICARE or CHAMPVA ☐ Other _____
☐ Spouse/Domestic Partner covered by employer's group medical coverage
☐ Spouse/Domestic Partner covered by employer's group dental coverage

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 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)***
X Employee Signature	

E. Dependent Information

Does any dependent listed in Section C live at another address? ☐ Yes ☐ No
If Yes, who and what address?

If any dependent's last name differs from yours, explain the circumstances.

F. Other Insurance

If you have checked "Yes" to Other **Health** Coverage (Section C), provide name and policy number of insurance carrier, HMO, or other source; a copy of the insurance card; and the start date of coverage

If you have checked "Yes" to Other **Dental** Coverage (Section C), provide name and policy number of insurance carrier, HMO, or other source; a copy of the insurance card; and the start date of coverage

Is your Spouse/Domestic Partner employed? ☐ Yes ☐ No If "Yes," provide name and address of spouse/domestic partner's employer.

PROOF OF PRIOR COVERAGE - IMPORTANT (*Required for other than Life Insurance*)
Does anyone enrolling on this enrollment form have prior coverage?
☐ Yes ☐ No If you answered "Yes", provide applicant names, start and end dates of prior coverage.

_____
_____
_____
_____
_____

Proof of coverage must accompany this enrollment form for pre-existing condition credit or waiver of dental waiting period.

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.

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 Primary Care Plan HMO, Aetna QPOS, and Aetna NYC Community Plan℠: Aetna Health Inc. and Aetna Health Insurance Company of New York
   - Aetna Managed Choice Plan PPO: Aetna Life Insurance Company
   - Life, Accidental Death & Dismemberment, DMO®, Dental PPO and all other health coverages: Aetna Life Insurance Company.

continued on next page

Conditions of Enrollment *(continued)*

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 enrollment form and employer application have been accepted and approved by Aetna. Even if this enrollment form is approved, any material misstatements or omissions may result in future claims being contested and the policy or my coverage under the policy being contested.
   For life 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. 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. Life insurance is incontestable after two years from date of issue, except for non-payment of premiums.
3. I understand and agree that this enrollment form may be transmitted to Aetna or its agent by my employer or its agent.
4. The plan certificate of coverage 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, 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. I understand and agree that, as described in the plan documents and when enrolled for medical coverage, any pre-existing conditions for my spouse/domestic partner, dependents or myself may not be covered for 12 months. This does not apply to life insurance coverage.

Misrepresentation **(This fraud warning is not applicable to an application for life insurance.)**

8. 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 (2 – 50 Eligible Employees) 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 per week for this employer at the regular place of business.

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

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