



Enrollment/Change Request

Aetna Health Inc.

Employer Group Information (To Be Completed by Employer)	Group Name / Employer Name - Full Name of Business or Organization	Control	Suffix	Account	Plan Number
		Group Number	Class Code		

A. Type of Activity - Employee Completes Sections A - E. Please Print Clearly.

Instructions: Refer to the instructions on the back before completing this form. You must complete this application in full or it will be returned to you resulting in a delay in processing. You are solely responsible for its accuracy and completeness.	Enrollment <input type="checkbox"/> New Enrollee/Subscriber Effective Date: / / Date of Hire: / /	Change - Check all that apply. <input type="checkbox"/> Add Spouse <input type="checkbox"/> Add Dependent Child <input type="checkbox"/> Name Change <input type="checkbox"/> Other <input type="checkbox"/> Change Plan <input type="checkbox"/> Control/Suffix/Acct/Plan	Date of Event: / / Reason: _____	Remove or Terminate - Check all that apply. <input type="checkbox"/> Remove Spouse <input type="checkbox"/> Remove Dependent Child <input type="checkbox"/> Employee Withdrawal/Termination Effective Date: / / Reason: _____	Continuation of Coverage, i.e., COBRA, State - Not all options are available. Contact Employer for available options. Coverage For: <input type="checkbox"/> Employee <input type="checkbox"/> Dependents Length of Continuation (months): <input type="checkbox"/> 18 <input type="checkbox"/> 36 <input type="checkbox"/> Other _____ <input type="checkbox"/> 29 - Attach disability determination from the Social Security Admin. Date of Loss of Coverage: / / Date of Qualifying Event: / / Continuation of Coverage Expiration Date: / /
--	---	---	-------------------------------------	---	--

B. Employee Information

Social Security Number	Last Name, First Name, M.I.			Home Telephone ()
Home Address	Apt. No.	City, State	ZIP Code	
Employer Name	Work Telephone ()			
Work Address	City, State	ZIP Code		

C. Plan Options - Your selection(s) must be offered by your employer.

<input type="checkbox"/> HMO <input type="checkbox"/> Aetna Open Access™ HMO <input type="checkbox"/> Aetna Choice™ POS <input type="checkbox"/> AHF Choice POS <input type="checkbox"/> Aetna Health Network Option™ <input type="checkbox"/> Aetna Health Network Only™	<input type="checkbox"/> QPOS® <input type="checkbox"/> Aetna HealthFund™ <input type="checkbox"/> Aexcel® <input type="checkbox"/> Aexcel® Plus	Available options with Aetna Health Network Option and Aetna Health Network Only. Check all that apply.	Indicate Plan Name Primary Copay: <input type="checkbox"/> \$5 <input type="checkbox"/> \$10 <input type="checkbox"/> \$15 <input type="checkbox"/> Other \$ _____
--	---	---	--

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage.

* Provide details for "Yes" responses below.

Attach sheet to list additional children. Attach proof if full-time college student.

(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex M F	Birthdate MM DD YYYY	Social Security Number (If dependent has no SSN, write "None")	Other Medical Coverage	Other Rx Drug Coverage	Handi-capped	Student	Primary Medical Office ID Number	Current Patient	Dentist Office ID Number (If applicable)	Current Patient	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"/> <input type="checkbox"/>	/ /		<input type="checkbox"/> Yes* <input type="checkbox"/> No	<input type="checkbox"/> Yes* <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> N/A		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Code Other
Spouse		<input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/> Yes* <input type="checkbox"/> No	<input type="checkbox"/> Yes* <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> N/A		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Child		<input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/> Yes* <input type="checkbox"/> No	<input type="checkbox"/> Yes* <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> N/A		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Child		<input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/> Yes* <input type="checkbox"/> No	<input type="checkbox"/> Yes* <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> N/A		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Child		<input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/> Yes* <input type="checkbox"/> No	<input type="checkbox"/> Yes* <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> N/A		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	

1. If "Yes" to Other Medical Coverage above, provide effective dates, name & policy number of insurance carrier, HMO, or other source and your Member Identification Number.	3. Does any dependent listed above live at a different address than the employee? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," who and what address? Explain the circumstances:	4. If any dependent's last name differs from yours, explain the circumstances.
2. If "Yes" to Other Rx Drug Coverage above, provide effective dates, name & policy number of insurance carrier, HMO, or other source and your Member Identification Number.		5. Is your spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," provide name and address of spouse's employer.

E. Employee Signature

By checking this box you agree to use Aetna Navigator, Aetna's member self-service website, for all future printed materials and understand you may choose to receive paper documents in the future.

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

I certify that all information supplied in this form is true and complete to the best of my knowledge and/or belief. I have read and agree to the Conditions of Enrollment on the reverse side of this Enrollment/Change Request form.	Employee Signature - Required X	Primary Language Spoken
	Date: / /	
	E-Mail Address	

Employee copy may be used as a temporary ID card for 30 days from the effective date if authorized by employer. Coverage must be verified with Aetna prior to visiting a specialist or admission to a hospital.