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.

Aetna®

CORPORATE HEALTH INSURANCE AN AETNA COMPANY

Texas Small Group Business Employee Enrollment/Change Form

Social Security Number

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 G.

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.	Control/Group No.	Suffix	Account	Plan No.

1. Medical - Check one.

- ☐ Aetna QPOS Plan – Plan _____
- ☐ Aetna OA POS Plan – Plan _____
- ☐ Aetna OA MC Plan – Plan _____
- ☐ Aetna PPO Plan – Plan _____
- ☐ Aetna Indemnity Plan
- ☐ Packaged Dental/Life/Disability Plan _____

2. Dental - Check one.

- ☐ Option 1
- ☐ Option 2
- ☐ Option 3: ☐ DMO® *or* ☐ PDN
- ☐ Option 4
- ☐ Option 5
- ☐ Option 6
- ☐ Other _____

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.*

Member ID Number (If Available)	Last Name, First Name, M.I.	Job Title	Home Telephone

Home Address	Apt. No.	City, State	ZIP Code

Work Address	City, State	ZIP Code	Work Telephone

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

Subscriber Primary Language (other than English) Primer Idioma del suscriptor (que no sea el Ingles)	Subscriber Disability
What is your primary Language? ¿Cuál es su primer idioma? _____	Do you have a disability which affects your ability to communicate or read? ☐ Yes ☐ No If Yes, please indicate the nature of your disability. _____

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

NOTE: Enter Domestic Partner ONLY if your employer has elected that coverage.

(A)dd (C)hange (R)emove	Name (Last, First, M.I.)	Sex M/F	Social Security Number	Birthdate (MM/DD/YYYY)	Height (ft. in)	Weight (lbs)	Incapacitated	Coverage Election	Other Health Coverage	Other Dental Coverage	Student Age 19 or Older (for Life/AD&D only)	Primary Office ID Number (if applicable)	Current Patient	Dental Office ID Number (if applicable)	Current Patient
	Employee 1.						Yes N/A	☐ Medical ☐ Dental ☐ Life/Dis	Yes ☐	Yes ☐	Yes N/A		Yes ☐		Yes ☐
	☐ Spouse ☐ Domestic Partner 2.						N/A	☐ Medical ☐ Dental ☐ Life	☐	☐	N/A		☐		☐
	Child 3.						☐	☐ Medical ☐ Dental ☐ Life	☐	☐	☐		☐		☐
	Child 4.						☐	☐ Medical ☐ Dental ☐ Life	☐	☐	☐		☐		☐

D. 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.

Social Security Number

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 1. ☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latin – 03 ☐ Asian – 04 ☐ Other – 05 _____	Child 3. ☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latin – 03 ☐ Asian – 04 ☐ Other – 05 _____
Spouse/Domestic Partner 2. ☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latin – 03 ☐ Asian – 04 ☐ Other – 05 _____	Child 4. ☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latin – 03 ☐ Asian – 04 ☐ Other – 05 _____

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 start date of the 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 start date of the 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)*

Does anyone enrolling on this enrollment form have prior coverage? If Yes, provide the information requested in the table below.
Medical ☐ Yes ☐ No Dental ☐ Yes ☐ No

Proof of coverage must accompany this enrollment form for pre-existing condition credit if enrolling in other than an HMO plan. 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 if enrolling in other than an HMO plan. 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
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No

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

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 Number _____
☐ Enrolled in other Insurance Carrier Plans - Carrier Name and ID Number _____
☐ Spouse/Domestic Partner covered by employer's group medical coverage
☐ Spouse/Domestic Partner covered by employer's group dental coverage
☐ Medicare ☐ Covered by TRICARE or CHAMPVA ☐ Other (Explain): _____

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.

Please sign here ONLY if you are declining coverage for yourself or dependent(s). | ***Date (Month/Day/Year)***

X Employee Signature

H. Health Questionnaire for Groups With 2 – 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 application will be returned.
- Incomplete applications may delay the effective date of your coverage.

In the past five (5) years, have you, your spouse/domestic partner or any of your dependents:	Yes	No
1. Had, consulted for, had treatment rendered, been advised to have treatment or been hospitalized for any of the following: Cardiovascular disease or heart attack; high blood pressure, stroke; disorder of the kidneys, stomach, intestines or liver; hepatitis; musculoskeletal conditions; mental or nervous condition; central nervous system disorder; transplant; diabetes; any disorder of the lungs or respiratory system; or cancer?	☐	☐
2. Has any person to be covered had or been told they have an immune disorder, AIDS or AIDS-Related Complex by a physician/medical doctor?	☐	☐
3. Have you or any dependents to be covered visited a healthcare professional for any illness and/or medical condition resulting in medical expenses more than $5,000 in the past 24 months?	☐	☐
4. Have you or any dependent to be covered been advised in the last 12 months that hospitalization, surgery or treatment is needed or pending?	☐	☐
5. Is any female to be covered currently pregnant?	☐	☐
6. Does anyone listed on this enrollment form use tobacco products, including cigarettes, pipe, cigar, or chewing tobacco?	☐	☐
7. Has any applicant taken any prescribed medications in the past 6 months? If Yes, list on next page.	☐	☐

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

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

Social Security Number

I. Health Questionnaire - Details for "Yes" Responses in Section H

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS IN SECTION H, YOU MUST COMPLETE THE FOLLOWING.
Please provide us with FULL DETAILS for each "Yes" answer to any condition(s) checked on Page 2. 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.)*

Ques No.	Name of Individual	Condition/Diagnosis	Date of Onset	Date Treatment Ended	Still Under Treatment ☐ Yes ☐ No	Still Takiing Medication ☐ Yes ☐ No
	Treatment Given			Medication Prescribed		Dosage
Ques No.	Name of Individual	Condition/Diagnosis	Date of Onset	Date Treatment Ended	Still Under Treatment ☐ Yes ☐ No	Still Takiing Medication ☐ Yes ☐ No
	Treatment Given			Medication Prescribed		Dosage
Ques No.	Name of Individual	Condition/Diagnosis	Date of Onset	Date Treatment Ended	Still Under Treatment ☐ Yes ☐ No	Still Takiing Medication ☐ Yes ☐ No
	Treatment Given			Medication Prescribed		Dosage
Ques No.	Name of Individual	Condition/Diagnosis	Date of Onset	Date Treatment Ended	Still Under Treatment ☐ Yes ☐ No	Still Takiing Medication ☐ Yes ☐ No
	Treatment Given			Medication Prescribed		Dosage
Ques No.	Name of Individual	Condition/Diagnosis	Date of Onset	Date Treatment Ended	Still Under Treatment ☐ Yes ☐ No	Still Takiing Medication ☐ Yes ☐ No
	Treatment Given			Medication Prescribed		Dosage
Ques No.	Name of Individual	Condition/Diagnosis	Date of Onset	Date Treatment Ended	Still Under Treatment ☐ Yes ☐ No	Still Takiing Medication ☐ Yes ☐ No
	Treatment Given			Medication Prescribed		Dosage
Ques No.	Name of Individual	Condition/Diagnosis	Date of Onset	Date Treatment Ended	Still Under Treatment ☐ Yes ☐ No	Still Takiing Medication ☐ Yes ☐ No
	Treatment Given			Medication Prescribed		Dosage
Ques No.	Name of Individual	Condition/Diagnosis	Date of Onset	Date Treatment Ended	Still Under Treatment ☐ Yes ☐ No	Still Takiing Medication ☐ Yes ☐ No
	Treatment Given			Medication Prescribed		Dosage
Ques No.	Name of Individual	Condition/Diagnosis	Date of Onset	Date Treatment Ended	Still Under Treatment ☐ Yes ☐ No	Still Takiing Medication ☐ Yes ☐ No
	Treatment Given			Medication Prescribed		Dosage
Ques No.	Name of Individual	Condition/Diagnosis	Date of Onset	Date Treatment Ended	Still Under Treatment ☐ Yes ☐ No	Still Takiing Medication ☐ Yes ☐ No
	Treatment Given			Medication Prescribed		Dosage

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 HMO Plan: Aetna Health Inc.
   - Aetna Quality Point-of-Service/Point-of-Service Plans: Aetna Health Inc. (In-Network) and Corporate Health Insurance Company, (Out-of-Network)
   - Aetna Dental DMO: Aetna Dental Inc.
   - Life, disability, dental and all other health 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 the eligible employee and employer applications have been accepted by Aetna. Even if this enrollment form is accepted, any intentional misstatement or omission of material fact may result in future claims being denied.
   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"), to give to Aetna or its agent information concerning the medical 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. This authorization will remain valid for the term of the coverage and so long thereafter 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 in other than an HMO plan, any pre-existing conditions for my spouse/domestic partner, dependents or myself may not be covered for 12 months.

Misrepresentation

8. It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. In addition, an insurer may deny insurance benefits if false information materially related to the claim was provided by the applicant.

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 on this **Texas** Small Group Business 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, and I am working full time, usually 30 hours per week, for this employer at the regular place of business.

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

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