aetna®

Virginia Employee Enrollment/Change Form

(1 to 50 employees)

Aetna Life Insurance Company, Aetna Health Inc.

Life, Accidental Death & Personal Loss Coverage (AD&PL), Short Term Disability (STD), Aetna Vision℠ Preferred plans, and Aetna Preferred Provider Organization (PPO) plans are underwritten by Aetna Life Insurance Company. Aetna HMO plans are underwritten by Aetna Health Inc. Aetna DNO* and Dental Preferred Provider Organization (PPO) plans are underwritten by Aetna Life Insurance Company. For Vision coverage, certain claims administration services are provided by First American Administrators, Inc. and certain network administration services are provided through EyeMed Vision Care, LLC ("EyeMed").

***DNO (Dental Network Only) in Virginia is not an HMO. To receive maximum benefits, members must choose a participating primary dentist to coordinate their care with in-network providers.**

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 B.** 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** ☐ **State continuation** 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.*

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 telephone ( ) -	Work telephone ( ) -		Primary language spoken (optional)	Number of dependents, including spouse or domestic partner, enrolling for medical coverage

Salary (if enrolling for life or disability coverage) $ _____	☐ Hourly ☐ Weekly ☐ Monthly	Number of hours worked a week	Check one: ☐ Full time ☐ Part time ☐ 1099 ☐ Retiree ☐ Seasonal ☐ Temporary ☐ COBRA ☐ Union

B. 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:	☐ Medical ☐ Dental ☐ Vision ☐ STD ☐ Life / AD&PL	**Reason for declining coverage** ☐ Parental group coverage ☐ Spouse group coverage ☐ 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:	☐ Medical ☐ Dental ☐ Vision ☐ Life	
☐ Domestic partner:	☐ Medical ☐ Dental ☐ Vision ☐ Life	
☐ Child(ren):	☐ Medical ☐ Dental ☐ Vision ☐ Life	

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 dependent(s).	***Date (Month/Day/Year)***
☐ I am declining coverage. **Employee signature:** **X**	
Please PRINT employee name:	

C. Coverage selection – ***Please print clearly. (Top boxes for employer and Aetna use only.)***

Control/Group number	Suffix	Account	Plan number	Class code

1. Medical

☐ **VA HMO** – Plan option _____

☐ **VA PPO** – Plan option _____

Control/Group number	Suffix	Account	Plan number

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

Non-voluntary plans – Plan number _____ Plan name _____

If FOC, choose: ☐ DNO *or* ☐ PPO

Voluntary plans – Plan number _____ Plan name _____

If FOC, choose: ☐ DNO *or* ☐ PPO

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

Control/Group number	Suffix	Account	Plan number

3. Vision

Aetna Vision℠ Preferred ☐ Yes ☐ No

Control/Group number	Suffix	Account	Plan number

4. Life and short term disability ☐ Yes ☐ No *Check all that apply.*

☐ Basic Life / AD&PL ☐ Short Term Disability

☐ Optional dependent term life (for groups with 10 to 50 eligible employees)

D. Individuals covered – ***List individuals for whom you are enrolling or adding, changing or removing coverage. Add more sheets if needed.***
NOTE FOR MEDICAL COVERAGE: While the Affordable Care Act mandates coverage of dependent children up to age 26, your plan may allow coverage beyond age 26. Please refer to your plan documents or contact your benefits administrator.

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: ☐ Medical ☐ Dental ☐ Vision ☐ STD ☐ Life / AD&PL	
Primary care physician (PCP) provider ID number	Current patient ☐ Yes	Dental provider office ID number	Current patient ☐ Yes

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: ☐ Medical ☐ Dental ☐ Vision ☐ Life			
PCP provider ID number	Current patient ☐ Yes	Dental provider office ID number	Current patient ☐ Yes	

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: ☐ Medical ☐ Dental ☐ Vision ☐ Life		
PCP provider ID number	Current patient ☐ Yes	Dental provider office ID number	Current patient ☐ Yes	

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: ☐ Medical ☐ Dental ☐ Vision ☐ Life		
PCP provider ID number	Current patient ☐ Yes	Dental provider office ID number	Current patient ☐ Yes	

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: ☐ Medical ☐ Dental ☐ Vision ☐ Life		
PCP provider ID number	Current patient ☐ Yes	Dental provider office ID number	Current patient ☐ Yes	

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: ☐ Medical ☐ Dental ☐ Vision ☐ Life		
PCP provider ID number	Current patient ☐ Yes	Dental provider office ID number	Current patient ☐ Yes	

E. Dependent information

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

Name	Address

F. Coordination of benefits

Will you have other health 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

Conditions of enrollment

On behalf of myself and the dependents listed, 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 plans: Aetna Health Inc.
   - Aetna PPO plans: Aetna Life Insurance Company
   - Aetna Vision℠ Preferred plans: Aetna Life Insurance Company; certain claims adjudication and other administrative services are provided by First American Administrators, Inc. (an affiliate of EyeMed Vision Care, LLC) and / or its affiliates
   - Dental, life, short term disability and 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 until Aetna has approved both my employee enrollment form and the employer applications. Even if this application is approved, any misstatements or omissions may result in future claims being denied and the policy or my coverage under the policy being rescinded or reevaluated, as of the effective date, for eligibility and rating purposes. I may also be entitled to a refund of any paid premiums from the effective date of coverage if coverage is voided or rescinded. Aetna will provide at least 30 days advance written notice or electronic notice (if you have elected electronic notice) to any covered person who would be affected by the proposed rescission of coverage before coverage under the plan is rescinded, regardless of whether the rescission applies to the entire group or only to an individual within the group.

   For life coverage: I understand that the effective date of insurance for myself or for any of my dependents is subject to my being active 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. For Dependent Life, dependent children are eligible from birth up to their 26th birthday.

   For short term disability coverage: I understand that the effective date of my insurance is subject to my being active 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.
3. I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("providers"), including pharmacies and / or pharmacy database benefit managers, to give to the Aetna company(ies) underwriting coverage(s) for the product(s) checked in the Coverage selection section on page 2, or its (their) agent(s), information concerning the medical history, services or treatment provided to anyone listed on this Application, including those involving mental health, substance use disorder 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. This authorization is applicable to the Aetna company(ies) underwriting coverage(s) for the product(s) checked in section C on page 2. I have discussed the terms of this authorization with my spouse or domestic partner and competent adult dependents, and I have obtained their consent to those terms. This authorization will remain valid for 30 months from the date I signed it or in the case of the information described above being collected in connection with a medical claim, this authorization will be valid for the term of the coverage. In the case of a life claim, the authorization will remain valid for the duration of the claim. I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original. This authorization is voluntary. However, I understand that if I refuse to sign this authorization form, my ability to enroll in the plans described above may be affected. I have the right to revoke this authorization in writing to Aetna at any time except to the extent that my information has already been used or disclosed in reliance on this authorization.
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® and Aetna Specialty Pharmacy®, all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, and Aetna Specialty Pharmacy, LLC, are subsidiaries 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 DNO® 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.

Authorization

7. I authorize deductions from my earnings for any contributions required for coverage, and I agree to make any necessary payments as required for coverage.
8. I authorize the substitution of generic pharmaceuticals for the brand-name products, as provided by law, for prescriptions filled under any pharmacy benefit.

Misrepresentation

9. Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

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 statement on this 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 eligibility and my dependents' eligibility may be affected.

I am employed by the employer shown on page 1. I am working full time at least 30 hours a week for this employer at the regular place of business.

If you wish to receive documents online, please visit your secure member account at aetna.com/individuals-families/aetna-navigator.html

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

If enrolling in an HMO / Health Network Only or DNO® plan, I acknowledge that a PPO or dental PPO plan has been offered to me. ☐ Yes ☐ No

Insurance agent signature **X**	***Date (Month/Day/Year)***

Designation of beneficiary – Carefully review Conditions and instructions for designation of beneficiary below.

The Group Policy grants the member the authority to designate a beneficiary. A beneficiary is the person or entity who will receive the benefit payment. A primary beneficiary will be the first to receive the benefit. A contingent beneficiary will only receive the benefit payment if the primary beneficiary(ies) predeceases the insured or is otherwise barred by a state law and / or a legally binding document addressing benefit payments. The employee is automatically the primary beneficiary for dependent life and accidental death and personal loss coverage (AD&PL) benefits.

Beneficiary for:	**Full name(s) or entity (trust or estate)**	**Date of birth**	**Social Security number / tax ID number**	**Address** (number, street, apt. number, city, state, ZIP code)	**Phone**	**Relationship to employee**	**% of benefit** (must equal 100%)
Life Primary							
Life Contingent							

SPOUSAL CONSENT FOR COMMUNITY PROPERTY STATES ONLY – see Conditions and instructions for designation of beneficiary section below.

Please note that an employee is under no obligation to complete the spousal consent section on this form.

I am aware that my spouse, the employee named above, has designated someone other than me to be the beneficiary of group life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.

Spouse signature _____ **Date** _____

Conditions and instructions for designation of beneficiary

Conditions for designation of beneficiary

- **Please note:** The Group Policy grants only the member the authority to designate a beneficiary. If you do not name a beneficiary, payment will be made to your survivors as described in the Group Policy's beneficiary provision. You should execute the Designation of beneficiary section of this form to ensure payment is made to the person you want.
- Unless otherwise expressly provided in the Designation of beneficiary section of this form, if any named primary beneficiary predeceases you, the life proceeds shall be paid equally to the remaining named primary beneficiary or beneficiaries. All primary beneficiaries must predecease you before the life proceeds will be paid to any contingent beneficiaries.
- If this Designation of beneficiary provides for payment to a trustee under a trust agreement, Aetna Life Insurance Company (Aetna) shall not be obliged to know or be liable under the terms and conditions of the trust agreement. If your beneficiary is a minor at the time of your death, Aetna may require the court to appoint a guardian to receive the life proceeds for the minor.
- Aetna will be fully discharged of its duties when payment is made. Aetna is not responsible for how the payment is used.
- If you live in one of the following community property states – Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin – your spouse may have a legal claim for a portion of the life insurance benefit under state law. If you name someone other than your spouse as beneficiary, payment of the death benefit may be delayed until your spouse's claim is resolved.

Instructions for designation of beneficiary

If these instructions do not answer all your questions, please contact your plan sponsor for assistance.

- If you make a mistake in completing this form, line out the erroneous information, add the correct information and initial the correction. **The printed material on this form should not be deleted or altered in any way.**
- **In all cases**, the relationship of the beneficiary, the beneficiary's Social Security number, address and phone number should be included with the beneficiary designations.
- **Dollars and cents should not be specified**.
- If a minor child is named beneficiary, the child will not receive the benefits until age of majority.
- If a trustee is named beneficiary, show the exact name of the trust, date of the trust agreement, and the name and address of the trustee. **For example**, The John J. Smith Revocable Life Insurance Trust, dated January 1, 1994. John Smith, Trustee, 123 Apple Lane, Hartford, CT 06006.