aetna® Texas Employee Enrollment/Change Form 2 - 100 employees

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 A and F.**	**Member Aetna ID (if available)**

Company Name			
Effective Date **Date of Hire** **BWP** ☐ Class 1 ☐ Class 2	☐ New Hire ☐ Rehire/Reinstatement* ☐ New Group Enrollment ☐ Late Enrollment ☐ Waiver ☐ Open Enrollment *Does not apply to Supplemental or Dependent Life Insurance	☐ Add Spouse ☐ Add Domestic Partner ☐ Add Dependent Child ☐ Change of Coverage ☐ Name Change	☐ Employee Termination ☐ Remove Spouse ☐ Remove Domestic Partner ☐ Remove Dependent Child ☐ Cancel Coverage ☐ Other _____
☐ COBRA ☐ State Continuation: ☐ Employee ☐ Dependent COBRA Length of Continuation: ☐ 18 mos ☐ 36 mos ☐ Other _____ Qualifying Event _____ Original Qualifying Event Date _____ Loss of Coverage Date _____			

A. Employee information – *Must be completed by the employee.*

Social Security Number	Last Name, First Name, M.I.		Job Title	
Home Address		Apt. No.	City, State	ZIP CODE
Home Address			City, State	ZIP CODE
Home Telephone ( ) -	Work Telephone ( ) -	No. of Hours Usually Worked Per Week	Number of Dependents (including Spouse/ Domestic Partner) enrolling for medical coverage	

Salary (if enrolling for life coverage) ☐ Hourly ☐ Weekly ☐ Monthly **$**	Check One ☐ Full-Time ☐ 1099 ☐ Union ☐ Seasonal ☐ Part-Time ☐ Retiree ☐ COBRA ☐ Temporary
Subscriber Primary Language (other than English) **Primer Idioma del suscriptor (que no sea el Ingles)** What is your primary Language? ¿Cual es su primer idioma? _____	**Subscriber Disability** Do you have a disability which affects your ability to communicate or read? ☐ Yes ☐ No If Yes, please indicate the nature of your disability. _____

B. Coverage Selection - Please print clearly, using black ink. (Shaded sections for Employer/Aetna Use Only)

Control/Group No.	**Suffix**	**Account**	**Plan No.**	**Class Code**

1. Medical – *Check one:*

☐ Aetna PPO TX OAMC 2000 70/50 Basic

☐ Aetna PPO TX OAMC 2000 90/50 HSA

Social Security Number

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.***
NOTE FOR MEDICAL COVERAGE: While the Federal Patient Protection and Affordable Care Act mandates coverage of dependent children up to age 26, your plan may allow coverage beyond age 26. Some exceptions apply. Please refer to your plan documents or contact your benefits administrator.
You can select an OB/GYN but are not required to do so. Instead, you may receive obstetrical and gynecological services from your primary care physician.

1	(A)dd (C)hange ___ (R)emove	**Employee Name** (Last, First, M.I.)				Sex (M/F)	Birthdate (MM/DD/YYYY) / /	
Coverage Election ☐ Medical ☐ Dental ☐ Vision ☐ STD ☐ Life/AD&D Ultra® ☐ LTD ☐ Life & Disability Packaged Plan		If choosing HMO, Primary Office ID #	Current Patient Yes ☐	OB/GYN Office ID#	Current Patient Yes ☐	If choosing DMO, Primary Office ID #	Current Patient Yes ☐	
2	(A)dd (C)hange ___ (R)emove	**Name** (Last, First, M.I.) ☐ **Spouse** ☐ **Domestic Partner**			Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /	
Coverage Election ☐ Medical ☐ Dental ☐ Vision ☐ Disability ☐ Life/AD&D Ultra®		If choosing HMO, Primary Office ID #	Current Patient Yes ☐	OB/GYN Office ID#	Current Patient Yes ☐	If choosing DMO, Primary Office ID #	Current Patient Yes ☐	
3	(A)dd (C)hange ___ (R)emove	**Name** (Last, First, M.I.) ☐ **Child** ☐ **Stepchild** ☐ **Other**			Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /	
Coverage Election ☐ Medical ☐ Dental ☐ Life/AD&D Ultra® ☐ Vision		If choosing HMO, Primary Office ID #			Current Patient Yes ☐	If choosing DMO, Primary Office ID #	Current Patient Yes ☐	
Incapacitated ☐ Yes ☐ No								
4	(A)dd (C)hange ___ (R)emove	**Name** (Last, First, M.I.) ☐ **Child** ☐ **Stepchild** ☐ **Other**			Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /	
Coverage Election ☐ Medical ☐ Dental ☐ Life/AD&D Ultra® ☐ Vision		If choosing HMO, Primary Office ID #			Current Patient Yes ☐	If choosing DMO, Primary Office ID #	Current Patient Yes ☐	
Incapacitated ☐ Yes ☐ No								
5	(A)dd (C)hange ___ (R)emove	**Name** (Last, First, M.I.) ☐ **Child** ☐ **Stepchild** ☐ **Other**			Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /	
Coverage Election ☐ Medical ☐ Dental ☐ Life/AD&D Ultra® ☐ Vision		If choosing HMO, Primary Office ID #			Current Patient Yes ☐	If choosing DMO, Primary Office ID #	Current Patient Yes ☐	
Incapacitated ☐ Yes ☐ No								
6	(A)dd (C)hange ___ (R)emove	**Name** (Last, First, M.I.) ☐ **Child** ☐ **Stepchild** ☐ **Other**			Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /	
Coverage Election ☐ Medical ☐ Dental ☐ Life/AD&D Ultra® ☐ Vision		If choosing HMO, Primary Office ID #			Current Patient Yes ☐	If choosing DMO, Primary Office ID #	Current Patient Yes ☐	
Incapacitated ☐ Yes ☐ No								

Social Security Number

D. Dependent Information

List any dependent in Section C living at another address.	
Name	**Address**

E. Coordination of Benefits

Will you have other health insurance at the same time as this coverage? ☐ Yes ☐ No			
If Yes, will Aetna coverage being applied for replace your current in-force coverage? ☐ Yes ☐ No			
Name of Person	**Carrier Name**	**Name of Person**	**Carrier Name**

Declination/Waiver of Coverage - *Check all that apply.*

I understand I am eligible to apply for this coverage through my employer; however, I am waiving coverage as noted below.

☐ **Employee:**
- ☐ Medical ☐ Dental
- ☐ Life/AD&D Ultra® ☐ Vision
- ☐ STD ☐ LTD
- ☐ Life & Disability Packaged Plan

☐ **Spouse/Domestic Partner:**
- ☐ Medical ☐ Dental
- ☐ Life/AD&D Ultra® ☐ Vision

☐ **Child(ren):**
- ☐ Medical ☐ Dental
- ☐ Life/AD&D Ultra® ☐ Vision

Reason for declining coverage
- ☐ Spouse group coverage
- ☐ Parental group coverage
- ☐ Medicare
- ☐ Medicaid
- ☐ Retiree coverage
- ☐ Another group plan provided by my employer
- ☐ COBRA coverage
- ☐ Insurance through another job
- ☐ TRICARE Military coverage
- ☐ Individual coverage - On Exchange
- ☐ Individual coverage - Off Exchange
- ☐ I have no other coverage
- ☐ Other _____

I certify I have been given the right to apply for this coverage; however, I am waiving 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)***
X Employee Signature	

Social Security Number

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 (HNOnly) Plan: Aetna Health Inc.
   - Aetna Dental DMO: Aetna Dental Inc.
   - Aetna Vision: 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.
   - 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 misrepresentation of material fact may result in future claims being denied.
   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 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 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. 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. However, because this information is essential to the administration of the plans, I understand that my revocation of this authorization may result in cancellation of my enrollment in the plans described above.
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.

Misrepresentation

7. 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 intentional misrepresentation of material fact or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

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 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. I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments as required for coverage.
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.

If you wish to receive documents electronically, please refer to Aetna Navigator® at http://www.aetna.com/Indivlduals-families/aetna-navigator.html.

Please sign here ONLY if you are enrolling in coverage for yourself and/or dependents). ***Employee Signature*** ***X***	***Employee E-mail Address***	***Date (Month/Day/Year)***