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 the medical information pages are not visible.

aetna℠

Florida Group Business (2 - 100 Eligible Employees) Employee Enrollment/Change Form

Life, Accidental Death & Dismemberment, Disability, Aetna Managed Choice, and Aetna PPO plans are underwritten by Aetna Life Insurance Company. Aetna HMO and Aetna POS plans are underwritten by Aetna Health Inc. Dental plans are provided or administered by Aetna Life Insurance Company.

INSTRUCTIONS: Please be thorough and complete all sections that apply. You are solely responsible for its accuracy and completeness.

Member Aetna ID Number (if available)

Employer Name

Effective Date **Date of Hire**	☐ New Hire ☐ Rehire/Reinstatement ☐ New Group Enrollment ☐ Late Enrollment ☐ Other ______________	☐ Change of Coverage ☐ Add Spouse/Dependent Child ☐ Name Change ☐ Other ______________	☐ Employee Termination ☐ Remove Spouse/ Dependent Child ☐ Cancel Coverage	☐ COBRA ☐ State Continuation for: ☐ Employee ☐ Dependent Length of Continuation: ☐ 18 ☐ 36 ☐ Other _____ Original Qualifying Event Date __________________ Qualifying Event __________________

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**

1. Medical – 2 to 100 Group Size:

☐ **Aetna HNOnly (HMO OA)** – Plan Option: ________________________________

☐ **Aetna HNOption (POS OA)** – Plan Option: ________________________________

☐ **Aetna Managed Choice Open Access** – Plan Option: ________________________________

☐ **Other** – Plan Option: ________________________________

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

2. Dental – 2 to 100 Group Size Check one (if applicable):

Standard Plans:	**Voluntary Plans:**
☐ **Aetna Dental® Plan** – Plan Option: ____________________	☐ **Aetna Dental® Plan** – Plan Option: ____________________
☐ **Freedom of Choice:**	☐ **Freedom of Choice:**
☐ Managed Dental *or* ☐ PPO	☐ Managed Dental *or* ☐ PPO

Before today, were you covered under this employer's dental plan? ☐ Yes ☐ No

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

3. Life/Disability
2 to 50 Group Size- Check applicable boxes.
51 to 100 Group Size – Contact your Aetna Account Executive.

☐ Basic Life/AD&D Ultra® ☐ Optional Dependent Life
☐ Disability ☐ Life/Disability Packaged Plan

Beneficiary Designation – **Full Name** (First, Middle, Last)	Beneficiary Social Security Number	Relationship to Employee

B. Employee Information – If you are waiving coverage, complete sections B and H.

Social Security Number	Last Name, First Name, M.I.	Job Title

Home Address (P.O. Box not acceptable)	Apt. No.	City, State	ZIP Code
Work Address (P.O. Box not acceptable)		City, State	ZIP Code

Home Telephone	Work Telephone	Primary Language Spoken (Optional)	Number of Dependents including Spouse enrolling for coverage

Salary **$** ______________	☐ Hourly ☐ Weekly ☐ Monthly	No. of Hours Worked Per Week	Check One ☐ Full-Time ☐ 1099 ☐ Seasonal ☐ COBRA ☐ Part-Time ☐ Retired ☐ Temporary ☐ Union

C. Individuals Covered - ***List individuals for whom you are enrolling or adding/changing/removing coverage. Insert additional sheets if necessary.*** **NOTE FOR MEDICAL AND DENTAL 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 for medical plans and some dental plans. Some exceptions apply. Please refer to your plan documents or contact your benefits administrator.

Name (Last, First, M.I.)	**Sex** M/F	**Social Security Number**	**Birthdate** (MM/DD/**YYYY**)	**Height**	**Weight**	**Status**	**Coverage Election**	**PCP Provider ID Number**
Employee **1.**						☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated	☐ Medical ☐ Dental ☐ Life/Dis	
☐ **Spouse** ☐ **Other** **2.**						☐ Different Last Name	☐ Medical ☐ Dental ☐ Life	
☐ **Child** ☐ **Stepchild** ☐ **Other** **3.**						☐ Different Last Name ☐ Lives at another address ☐ Full-Time Student - Life Only ☐ Disabled	☐ Medical ☐ Dental ☐ Life	
☐ **Child** ☐ **Stepchild** ☐ **Other** **4.**						☐ Different Last Name ☐ Lives at another address ☐ Full-Time Student - Life Only ☐ Disabled	☐ Medical ☐ Dental ☐ Life	

D. Dependent Information

List any dependent in Section **C** living at another address.	Name:	Reason:	Address:
If any dependent's last name differs from yours, explain.	Name:	Reason:	

FOR DEPENDENT LIFE COVERAGE: If age 19 and over and a full-time student, provide information below.

Child Name	**School Name**	**Expected Graduation Date**	**Number of Credit Hours**

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 Latino – 03 ☐ Asian – 04 ☐ Other – 05 ____________________	**Child/Stepchild/Other** **3.** ☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 ____________________
Spouse/Other **2.** ☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 ____________________	**Child/Stepchild/Other** **4.** ☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 ____________________

F. Other Medical Insurance (Complete this section for anyone age 19 and older seeking medical coverage who has prior medical coverage.)

Proof of coverage may be provided now or after enrollment for pre-existing credit.. **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.

Name of Covered Individual	**Carrier Name**	**Group Number**	**Start Date**	**Termination Date**

G. Medicare Information

Name of Person	**Medicare Part A**	**Medicare Part B**	**Medicare Part D**	**Over Age 65**	**Disability**	**End-Stage Renal Disease Effective Date**
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

H. 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.	Print Employee Name
☐ **Medical declined for:** ☐ Myself ☐ Spouse ☐ Child(ren) ☐ **Dental declined for:** ☐ Myself ☐ Spouse ☐ Child(ren) ☐ **Life declined for:** ☐ Myself ☐ Spouse ☐ Child(ren) ☐ **Disability declined for:** ☐ Myself ☐ Spouse ☐ Child(ren)	**Reason for declining coverage** (If applicable attach front/back of your health ID card.) ☐ Spousal group coverage ☐ COBRA coverage ☐ Medicare ☐ TRICARE/Military coverage ☐ Medicaid ☐ Another group plan provided by my employer ☐ Individual coverage ☐ Do not want ☐ Retiree 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 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. **NOTE:** If your Plan contains a pre-existing conditions provision, the pre-existing conditions exclusion and limitation will not apply to a person under 19 years of age.	
Please sign here ONLY if you are declining coverage for yourself and/or your dependent(s). **Employee Signature X**	***Date (Month/Day/Year)***

I. Health Questionnaire – Must be completed if:

- New (to Aetna) Group is enrolling 2 to 9 eligible employees;
- **Life:** Group size 2 to 100 eligible employees requesting Life coverage above the Guarantee Issue amount or a Late Enrollee (enrolling more than 31 days after eligible);
- Group size 51 to 100 eligible employees with no group medical coverage through the current employer;
- Group size 51 to 100 eligible employees is a newly-formed business (in operation less than 3 months).

Health History for Employees and Their Dependents. ***The following information is confidential and will not be seen by or given to your employer.*** Incomplete enrollment forms may delay the effective date of your coverage.

1.	Within the last 24 months has anyone applying for coverage consulted, received treatment, by a doctor, psychiatrist, psychologist, or other practitioner or been diagnosed with any of the following conditions or disorders? (Check all that apply.) a. ☐ Infertility b. ☐ Endocrine/ Metabolic c. ☐ Pancreas d. ☐ Liver/Hepatitis e. ☐ Immune System (other than HIV) f. ☐ Blood Disorder g. ☐ Hemophilia h. ☐ Epilepsy/Seizure i. ☐ Heart j. ☐ Paralysis/Paresis k. ☐ Diabetes Date Diagnosed ____________ ☐ Insulin ☐ Non-Insulin l. ☐ Tumor/Cyst/Growth m. ☐ Systemic or Discoid Lupus n. ☐ Lung or Respiratory o. ☐ Alcohol or Drug Use p. ☐ Kidney/Bladder/Urinary q. ☐ Circulatory/Vascular r. ☐ Digestive/Stomach/Intestinal s. ☐ Central Nervous System t. ☐ Connective Tissue Disorder u. ☐ Pituitary/Adrenal/Growth Disorder v. ☐ Birth Defects/Congenital Abnormalities w. ☐ Arthritis/Bone/Joint/Muscle/Prosthetic Device x. ☐ Mental/Nervous/Emotional/Eating Disorder y. ☐ Stroke/Brain/Neurological z. ☐ Transplant: ☐ Recommended ☐ Pending ☐ Complete aa. ☐ Advised to have tests, surgery, hospitalization or is treatment needed, or course of treatment not yet determined bb. ☐ Cancer: Type:__________________ Stage ______ ☐ Surgery ☐ Chemo ☐ Radiation cc. ☐ Using: ☐ Crutches ☐ Walker ☐ Wheelchair	☐ Yes ☐ No
2.	To the best of your knowledge and belief, is any female currently pregnant? If so, provide due date ________________ Check applicable boxes: ☐ C section planned ☐ Multiple Births Expected (# _____) ☐ Complications: ☐ Past or ☐ Present	☐ Yes ☐ No
3.	Has anyone applying for coverage incurred medical expenses in excess of $10,000 in the past 24 months?	☐ Yes ☐ No
4.	Has anyone applying for coverage been prescribed medications in the past 12 months?	☐ Yes ☐ No
5.	Has anyone applying for coverage been hospitalized or had a surgical procedure in the past 24 months?	☐ Yes ☐ No
6.	Does anyone applying for coverage have a known condition that requires on-going treatment, as diagnosed by a licensed member of the medical profession?	☐ Yes ☐ No
7.	Do you or your spouse use tobacco products? If so, check the applicable boxes: ☐ Employee: ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Chewing Tobacco ☐ Spouse: ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Chewing Tobacco	☐ Yes ☐ No
	Has any person listed on this enrollment form been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	☐ Yes ☐ No

IF YOU ANSWERED "YES" TO QUESTIONS 1 through 7 ABOVE, YOU MUST COMPLETE SECTION J ON THE FOLLOWING PAGE.

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

IF YOU ANSWERED "YES" TO QUESTIONS 1 THROUGH 7 IN SECTION I (EXCEPT THE LAST QUESTION IN SECTION I), YOU MUST COMPLETE THE FOLLOWING TO THE BEST OF YOUR KNOWLEDGE AND BELIEF.

Please provide us with FULL DETAILS for each "Yes" answer to any condition(s) checked in Section I. **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/ Treatment	Date of Onset	Date Treatment Ended	Medication Prescribed	Dosage	Still Taking Medication
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

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:

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 POS plans: Aetna Health Inc.
   - Life, Accidental Death & Dismemberment, 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 enrollment form and employer applications have been accepted and approved by Aetna. ***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. For Dependent Life, dependents are eligible from 14 days of age up to their 19th birthday, or up to their 23rd birthday, if a full-time student.

continued on next page

Conditions of Enrollment *(continued)*

3. I understand and agree that this Enrollment/Change Request 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"), including pharmacies or pharmacy database benefit managers to give to Aetna or its agent information concerning the medical history, prescription utilization history, services or treatment provided to anyone listed on this Enrollment/Change Request 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 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 for 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. I may revoke my authorization to disclose nonpublic personal health information at any time. I can make this revocation by completing and returning to Aetna a Revocation of Authorization form that will be sent to me by Aetna upon my request. Aetna also will accept a form developed by my employer or my hand-written request for revocation of authorization. However, the employer form or my request must include all the data elements that are included in Aetna's standard revocation form.
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 Managed Dental 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. To the best of my knowledge and belief, I represent that all information supplied in this form is true and complete. On behalf of myself and the eligible persons listed herein, I acknowledge that I have read and understand this form in its entirety.

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 **Florida** 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 at least 25 hours per week for this employer at the regular place of business.

Fraud Statement: **Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.**

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