

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.



California Small Group Business (2 - 50 Eligible Employees) Employee Enrollment/Change Form

TO COMPLY WITH CALIFORNIA LAW WHEREVER THE TERM "SPOUSE" APPEARS IT SHALL BE CONSTRUED TO INCLUDE DOMESTIC PARTNER.

Coverage is provided by the following entities: Aetna Health of California Inc. for HMO, Aetna Dental of California Inc. for Dental (DMO® only) and Aetna Life Insurance Company for all other coverages.

Applicant 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 E only.									
Effective Date	<input type="checkbox"/> New Hire <input type="checkbox"/> Rehire/Reinstatement	<input type="checkbox"/> Add Spouse/Dependent Child <input type="checkbox"/> Change of Coverage <input type="checkbox"/> Name Change <input type="checkbox"/> Other _____	<input type="checkbox"/> Employee Termination <input type="checkbox"/> Remove Spouse/Dependent Child <input type="checkbox"/> Cancel Coverage	COBRA/Cal-COBRA for: <input type="checkbox"/> Employee <input type="checkbox"/> Dependent Length of Continuation: <input type="checkbox"/> 18 <input type="checkbox"/> 36 <input type="checkbox"/> Other _____ Original Qualifying Event Date _____					Date of Hire		<input type="checkbox"/> New Group Enrollment <input type="checkbox"/> Late Enrollment <input type="checkbox"/> Other _____

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. HMO: <input type="checkbox"/> 10/20 <input type="checkbox"/> 10/30 <input type="checkbox"/> 20/40 <input type="checkbox"/> 30/40 <input type="checkbox"/> HRA 750 25 <input type="checkbox"/> HRA 1500 40 <input type="checkbox"/> Deductible 1000 40 Aetna Value Network SM HMO: <input type="checkbox"/> 10/20 <input type="checkbox"/> 20/40 <input type="checkbox"/> 30/40 Vitalidad Mexico HMO: <input type="checkbox"/> 5 <input type="checkbox"/> 10 EPO: <input type="checkbox"/> EPO 80 <input type="checkbox"/> EPO Limited MC: <input type="checkbox"/> 250 90/70 <input type="checkbox"/> 250 80/60 <input type="checkbox"/> 500 80/60 <input type="checkbox"/> 1000 80/50/50 <input type="checkbox"/> 1000 70/50 <input type="checkbox"/> 2000 80/50/50 <input type="checkbox"/> Basic <input type="checkbox"/> HRA HDHP 3000 80/50 <input type="checkbox"/> HRA HDHP 5000 80/50 <input type="checkbox"/> HSA HDHP 2300 80/50 <input type="checkbox"/> HSA HDHP 3000 100/50 <input type="checkbox"/> HSA HDHP 3300 80/50 PPO: <input type="checkbox"/> 500 90/70 <input type="checkbox"/> Aetna Indemnity <input type="checkbox"/> Out-of-State					2. Dental - Check one. (if applicable) Standard Plans: <input type="checkbox"/> 1 - DMO® Access <input type="checkbox"/> 2 - DMO® Plus (Plan 58) <input type="checkbox"/> 3 - Freedom-of-Choice Basic: <input type="checkbox"/> DMO® or <input type="checkbox"/> PPO <input type="checkbox"/> 4 - Freedom-of-Choice Plus: <input type="checkbox"/> DMO® or <input type="checkbox"/> PPO <input type="checkbox"/> 5 - PPO 1000 Active <input type="checkbox"/> 6 - PPO 1500 <input type="checkbox"/> 7 - PPO 1500 Active <input type="checkbox"/> 8 - PPO 2000 <input type="checkbox"/> Out-of-State PPO Voluntary Plans: <input type="checkbox"/> Option V1 - DMO® Access <input type="checkbox"/> Option V2 - DMO® Plus (Plan 58) <input type="checkbox"/> Option V3 - PPO 1000 Active <input type="checkbox"/> Option V4 - PPO 1500 <input type="checkbox"/> Option V5 - PPO 1500 Active <input type="checkbox"/> Out-of-State PPO Before today, were you covered under this employer's dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No					3. Life <input type="checkbox"/> Basic Life/AD&D Ultra™ <input type="checkbox"/> Optional Dependent Life <hr/> Beneficiary Designation - Full Name (First, Middle, Last) _____ <hr/> Beneficiary Social Security Number _____ <hr/> Relationship to Employee _____		

B. Employee Information - Must be completed by the employee.

Member Aetna ID Number (if available)	Last Name, First Name, M.I.			Job Title	Home Telephone	Primary Language Spoken (Optional)
Home Address		Apt. No.	City, State		ZIP Code	
Work Address		City, State			ZIP Code	Work Telephone
Salary \$	<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	Number of Hours Worked Per Week	Check One <input type="checkbox"/> Full-Time <input type="checkbox"/> 1099 <input type="checkbox"/> Seasonal <input type="checkbox"/> Part-Time <input type="checkbox"/> Retiree <input type="checkbox"/> Temporary			Number of Dependents Including Spouse

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

1. Employee Name (Last, First, M.I.)					Sex (M/F)	Social Security Number			
Birthdate (MM/DD/YYYY)	Height (ft, in)	Weight (lbs)	Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow <input type="checkbox"/> Legally Separated	Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	PCP Provider Office ID Number	Current Patient Yes <input type="checkbox"/>	Dental Office ID Number (if applicable)	Current Patient Yes <input type="checkbox"/>	
2. Name (Last, First, M.I.)					Sex (M/F)	Social Security Number		Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Other	
Birthdate (MM/DD/YYYY)	Height (ft, in)	Weight (lbs)	Status <input type="checkbox"/> Different Last Name	Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	PCP Provider Office ID Number	Current Patient Yes <input type="checkbox"/>	Dental Office ID Number (if applicable)	Current Patient Yes <input type="checkbox"/>	
3. Child Name (Last, First, M.I.)					Sex (M/F)	Social Security Number		Relationship <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	
Birthdate (MM/DD/YYYY)	Height (ft, in)	Weight (lbs)	Status <input type="checkbox"/> Different Last Name <input type="checkbox"/> Lives at another address <input type="checkbox"/> Full-Time Student (19+) <input type="checkbox"/> Disabled (19+)	Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	PCP Provider Office ID Number	Current Patient Yes <input type="checkbox"/>	Dental Office ID Number (if applicable)	Current Patient Yes <input type="checkbox"/>	
4. Child Name (Last, First, M.I.)					Sex (M/F)	Social Security Number		Relationship <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	
Birthdate (MM/DD/YYYY)	Height (ft, in)	Weight (lbs)	Status <input type="checkbox"/> Different Last Name <input type="checkbox"/> Lives at another address <input type="checkbox"/> Full-Time Student (19+) <input type="checkbox"/> Disabled (19+)	Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	PCP Provider Office ID Number	Current Patient Yes <input type="checkbox"/>	Dental Office ID Number (if applicable)	Current Patient Yes <input type="checkbox"/>	

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:	
If age 19+ and a full-time student, provide the following:			
Child Name	School Name	Expected Graduation Date	Number of Credit Hours

E. 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.

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

<input type="checkbox"/> Employee	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Life	Reason for declining coverage (If applicable attach front/back of your health ID card): <input type="checkbox"/> Covered by spouse's group coverage - Carrier Name and ID number: _____ <input type="checkbox"/> Enrolled in other insurance (check applicable box): <input type="checkbox"/> Medicare <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> Military <input type="checkbox"/> Individual <input type="checkbox"/> COBRA <input type="checkbox"/> Retiree <input type="checkbox"/> Other _____ <input type="checkbox"/> Carrier Name and ID number: _____ <input type="checkbox"/> Spouse covered by employer's group coverage <input type="checkbox"/> Do Not Want
<input type="checkbox"/> Spouse	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Life	
<input type="checkbox"/> Child(ren)	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Life	

I certify 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 this plan, may not be covered for six months.

Please sign here **ONLY** if you are declining coverage for yourself and/or your dependent(s).

Employee Signature X	Date (Month/Day/Year)
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F. Medicare Information

Name of Person	Medicare Part A	Medicare Part B	Medicare Part D	Over Age 65	Disability	End-Stage Renal Disease Effective Date
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

G. Other Insurance

Does anyone enrolling on this enrollment form have current or prior coverage? Yes No

Proof of coverage must accompany this enrollment form for pre-existing condition credit and if an employee is waiving coverage. **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. 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
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

H. Health Questionnaire for Groups Enrolling 2 - 10 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 enrollment form will be returned.
- Incomplete enrollment forms may delay the effective date of your coverage.

In the past five (5) years, has any person listed on the enrollment form seen a health care provider(s), had treatment recommended, received treatment, including prescription medications or been hospitalized for any of the following conditions listed below? Yes No

1. Heart attack, heart murmur, stroke, chest pain, high blood pressure, anemia, varicose veins or other disorders of the heart, blood (except HIV infection), blood vessels or high cholesterol? Yes No
2. Ulcer, colitis, gallstones or any other disorder of the stomach, intestines, rectum, pancreas, liver or Hepatitis B or C? Yes No
3. Cancer, cyst or tumor? Yes No
4. Disorders of the kidneys, adrenal glands, thyroid gland, urinary system, male or female organs, infertility, menstrual dysfunction or sexually transmitted disease? Yes No
5. Asthma, emphysema, tuberculosis or any other disorders of the lungs or respiratory system? Yes No
6. Migraines, fainting spells, epilepsy, mental or nervous conditions, depression, paralysis or any disorder of the brain or nervous system? If epileptic, date of last seizure: ____ / ____ / ____ (month/day/year) Yes No
7. Lupus, arthritis, back trouble or any other disorder of the joints, muscles or bones, including prosthetic device or implants? Yes No
8. Any physical deformity, defect or congenital problem? Yes No
9. Has any person to be covered had or has been told that they have an immune deficiency disorder (except HIV), AIDS, or AIDS-Related Complex? Yes No
10. Has any person been treated for alcoholism, other drug or substance abuse, including use of any illegal or controlled drugs, or been advised to seek treatment for the same? Yes No
11. Has any person been diagnosed with diabetes? If Yes, list date of diagnosis: ____ / ____ / ____ (month/day/year) Yes No
 Insulin dependent Non-insulin dependent
12. a. Is any female to be covered currently pregnant? if Yes, list due date: ____ / ____ / ____ (month/day/year) Yes No
b. Have there been any complications thus far? Yes No
c. Are multiple births expected? Yes No
d. If you are a male listed on this enrollment form, are you expecting a child with anyone, even if the mother is not listed on this enrollment form? Yes No
13. Has any person taken any prescribed medications in the past 12 months? **If Yes, list on the following page.** Yes No
14. Has any person had an abnormal physical exam or been advised to undergo further testing, surgery or treatment? Yes No
15. Has any person been a patient in a hospital, clinic, surgical center, sanatorium or medical facility as an outpatient or inpatient (excluding childbirth)? Yes No
16. Does anyone named on this enrollment form use tobacco products, including cigarettes, pipe, cigars, or chewing tobacco? Yes No
If Yes, check applicable boxes. Employee Spouse
17. Within the past five years has any person had any medical condition or symptom not listed on this enrollment form? Yes No

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

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

Conditions of Enrollment (continued from Page 4)

For life 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 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"), 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 Form, including those involving mental health, substance abuse and 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. I have discussed the terms of this authorization with my spouse and competent adult dependents, and I have obtained their consent to those terms. I understand that this authorization is provided under state law, and that it is not an "authorization" within the meaning of the federal Health Insurance Portability and Accountability Act. This authorization is valid for 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 and when enrolled for medical coverage, any pre-existing conditions for my spouse, dependents or myself may not be covered for 6 months.

Misrepresentation

8. Attention California Residents: For your protection, California law requires notice of the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

To the best of my knowledge, 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 **California** Small Group Business (2 - 50 Eligible Employees) Employee Enrollment/Change Form. I understand in the event I fail to sign and return this form within 31 days of my eligibility date 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 30 hours per week for this employer at the regular place of business.

CA HMO ENROLLEES - NOTICE OF BINDING ARBITRATION: ANY DISPUTE ARISING FROM OR RELATED TO HEALTH PLAN MEMBERSHIP WILL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION, AND NOT BY A LAWSUIT OR RESORT TO COURT PROCESS EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. THE AGREEMENT TO ARBITRATE INCLUDES, BUT IS NOT LIMITED TO, DISPUTES INVOLVING ALLEGED PROFESSIONAL LIABILITY OR MEDICAL MALPRACTICE, THAT IS, WHETHER ANY MEDICAL SERVICES COVERED BY THIS AGREEMENT WERE UNNECESSARY OR WERE UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED. THE HEALTH PLAN AGREEMENT ALSO LIMITS CERTAIN REMEDIES AND MAY LIMIT THE AWARD OF PUNITIVE DAMAGES. SEE THE EVIDENCE OF COVERAGE FOR FURTHER INFORMATION.

I understand that I am giving up the constitutional right to have disputes decided in a court of law before a jury, and instead am accepting the use of binding arbitration. This means that members will not be able to try their case in court. I further understand that the agreement contains limitations on certain remedies and that there may be certain limitations to the recovery of punitive damages.

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