NOTE: Before you return this form to your employer, you may wish to tape or staple the form so that health information is not visible. This will help keep your health information private.

aetna®

Idaho Employee Enrollment/Change Form
(For groups with 51 to 100 employees)

Aetna PPO plans and Aetna Vision℠ Preferred plans are underwritten by Aetna Life Insurance Company. Dental plans are provided or administered by Aetna Life Insurance Company. Vision insurance 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").

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 G.** Please use only black ink to complete this form.

Group number
Aetna member ID number (if available)

Company name:			
Effective date **Date of hire** **Benefit waiting period*** ☐ Class 1 ☐ Class 2 * Only required when your employer has 2 benefit waiting periods	☐ 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** 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
Mailing address (not needed if same as above) If this is completed, this is the address that will be used for all mailings and communications. May be a PO box.			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 $ _____	☐ Hourly ☐ Weekly ☐ Monthly	Number of hours worked a week	Check one: ☐ Full time ☐ Part time ☐ 1099 ☐ Retiree ☐ Seasonal ☐ Temporary ☐ COBRA ☐ Union	

B. Coverage selection – *Please print clearly. (Top boxes for employer/Aetna-use only.)*

Control/Group number	**Suffix**	**Account**	**Plan number**	**Class code**
1. Medical – Check one (if applicable). ☐ Aetna PPO (available for employees outside the Health Network Option service area) – Plan option: _____				

Continued on next page

B. Coverage selection *(Continued)*

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: _____

Voluntary plans – Plan number: _____ Plan name: _____

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 ☐ Yes ☐ No

Aetna Vision℠ Preferred

C. 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		Primary care physician (PCP) provider ID number	Current patient ☐ Yes
2	☐ Add ☐ Change ☐ Remove	**Name** (Last, first, middle initial) ☐ **Spouse** ☐ **Domestic partner**			Sex (M/F)	Social Security number
Birth date (MM/DD/YYYY) / /	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision				PCP provider 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) / /	Status ☐ Different last name ☐ Incapacitated	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision			PCP provider 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) / /	Status ☐ Different last name ☐ Incapacitated	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision			PCP provider 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) / /	Status ☐ Different last name ☐ Incapacitated	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision			PCP provider 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) / /	Status ☐ Different last name ☐ Incapacitated	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision			PCP provider ID number	Current patient ☐ Yes

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 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

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
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

G. 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 ☐ Vision	☐ Dental
☐ Spouse / domestic partner:	☐ Medical ☐ Vision	☐ Dental
☐ Child(ren):	☐ Medical ☐ Vision	☐ Dental

Reason for declining coverage

- ☐ Parental group coverage
- ☐ Spouse / 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 _____

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:	

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 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 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.
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 health care professional, hospital or any other health care 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 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. Authorizations signed for the purpose of collecting information in connection with this application for an insurance policy, a policy reinstatement or a request for a change in policy benefits shall remain valid for thirty (30) months from the date it is signed. Authorizations signed for the purpose of collecting information in connection with a claim for benefits shall remain valid for the term of this coverage or for so long 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 medical 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 medical 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® 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.

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 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 or at least 25 hours or more a week for this employer at the regular place of business. I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments required for coverage.

Misrepresentation: 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 materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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)***

Company Name:
Employee Name:

H. Health questionnaire must be completed for all individuals enrolling for coverage.

Health history for you and your dependents. ***The following information is confidential and will not be seen by or given to your employer.***
You or your dependents must answer ALL of the questions. Incomplete enrollment forms may delay the date your coverage starts.

1. Within the last **five** years, has anyone applying for coverage consulted with or received treatment from a doctor, psychiatrist, psychologist, or other practitioner or been diagnosed with any of the following conditions or disorders? (Check all that apply.) ☐ Yes ☐ No

a. ☐ Diabetes
b. ☐ Infertility
c. ☐ Endocrine/ metabolic
d. ☐ Pancreas
e. ☐ Liver / hepatitis
f. ☐ Immune system
g. ☐ Blood disorder
h. ☐ Hemophilia
i. ☐ Epilepsy / seizure
j. ☐ Heart
k. ☐ Paralysis / paresis
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
dd. ☐ Other _____

2. Has any person listed on this enrollment form tested positive for exposure to the human immunodeficiency virus (HIV) or been diagnosed with acquired immune deficiency syndrome (AIDS) caused by HIV or other sickness or condition derived from this infection? Or has any person listed on this enrollment form been diagnosed with AIDS-related complex (ARC)? ☐ Yes ☐ No

3. Is anyone currently pregnant? Due date _____ Check applicable boxes: ☐ C section planned ☐ Multiple births expected (Number _____) ☐ Complications: ☐ Past or ☐ Present ☐ Yes ☐ No

4. Has anyone applying for coverage had more than $5,000 in medical expenses in the past 24 months? ☐ Yes ☐ No

5. Has anyone applying for coverage been prescribed medications in the past 12 months? ☐ Yes ☐ No

6. Does anyone applying for coverage have a known condition that requires ongoing treatment? ☐ Yes ☐ No

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS IN SECTION H, YOU MUST COMPLETE SECTIONS I and J.

I. Health questionnaire – Details for "Yes" answers in Section H.

List all individuals enrolling for coverage. Name	Age	Height	Weight	Cigarette smoker	Currently taking prescription medication(s)
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No

J. Provide details below to any boxes checked above. (If additional space is needed, attach a separate sheet and be sure to sign and date the sheet.)

Ques. No.	Name	Condition / diagnosis / treatment	Date of onset	Date treatment ended	Names of prescription medication	Dosage	Still taking medication
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

Employee signature (required)	*Date (Month/Day/Year)*