aetna®

Idaho Supplemental Employee Enrollment/Change Form (2-50 eligible employees)

Life, Accidental Death & Personal Loss Coverage (AD&PL), Short Term Disability (STD), Aetna Vision℠ Preferred plans, and Aetna PPO plans are underwritten by Aetna Life Insurance Company. Dental plans are provided or administered 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").

A. Employer information

Employer company name	**Group number/control number** (if a current Aetna customer)

B. Enrollment information

Effective date	**Employee name**	**Social Security number**

Work address

Date of birth	**Date of hire**	**Salary** (for life coverage) $ _____ ☐ Hourly ☐ Monthly ☐ Weekly

Enrollment – Check all that apply

☐ New group enrollment ☐ New hire ☐ Late enrollee ☐ Other _____

☐ Rehire / reinstatement - does not apply to supplemental or dependent life insurance

C. Coverage selection

Control/Group number	**Suffix**	**Account**	**Plan number**	**Class code**

1. Medical – *Check applicable boxes.* ☐ **Employee** ☐ **Spouse** ☐ **Domestic partner** ☐ **Child**

☐ **PPO** (available for employees outside the Health Network Option service area) – Plan option _____

Control/Group number	**Suffix**	**Account**	**Plan number**

2. Dental – *Check applicable boxes.* ☐ **Employee** ☐ **Spouse** ☐ **Domestic partner** ☐ **Child**

Non-voluntary plans: ☐ Aetna Dental® Plan – Plan option _____

Voluntary plans: ☐ Aetna Dental® Plan – Plan option _____

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 Hires 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 (if applicable) *Check applicable boxes.* ☐ **Employee** ☐ **Spouse** ☐ **Domestic partner** ☐ **Child**

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)

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D. Changes – *Check all that apply.*

	Name	Date of birth	Social Security number	Date of event	Reason
☐ Add spouse*					
☐ Add domestic partner*					
☐ Add child*					
☐ Name change					
☐ Change plan					
☐ Other					

**Employee must be enrolled for spouse/domestic partner and dependent(s) to enroll for coverage.*

E. Remove or terminate – *Check all that apply.*

	Date of event	Reason
☐ Employee termination		
☐ Remove spouse		
☐ Remove domestic partner		
☐ Remove child Name		
☐ Cancel coverage		

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:
   - 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;
   - Life, Accidental Death & Personal Loss Coverage, short term disability, dental and all other coverages: Aetna Life Insurance Company.
2. I understand and agree that my employer's enrollment form 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. Even if this enrollment form is approved, any misstatements or omissions may result in future claims being denied, as of the effective date, for eligibility and rating purposes.
   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 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 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 / 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, as is any authorized representative that I may designate, 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. Authorizations signed for the purpose of collecting information in connection with this enrollment form 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 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. The information, as well as other personal or privileged information, subsequently collected by the insurance institution or agent may, in certain circumstances, be disclosed to third parties without authorization. A right of access and correction exists with respect to all personal information collected. Further disclosures required by **Idaho** law will be furnished to the policyholder upon request. Personal information may be collected from persons other than the individual or individuals proposed for coverage.

Continued on next page

Conditions of enrollment *(Continued)*

5. 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.
6. I understand and agree that, with the exception of Aetna Rx Home Delivery® and Aetna Specialty Pharmacy®, providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.
7. I understand and agree that, with certain exceptions described in the plan documents, 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

8. 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.

I represent that all information supplied in this form is true and complete. I have read and agree to the Conditions of Enrollment on this **Idaho** Supplemental 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, and I am working full-time at least 30 hours a week (or 20 hours per week if my employer extends coverage) for this employer at the regular place of business. I authorize deductions from my earnings for any premium contributions required for coverage and I agree to make any necessary payments as required for coverage.

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

Employee signature	***Employee email***	***Date (Month/Day/Year)***
X		

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.