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.

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

Aetna Vision℠ Preferred plans, Aetna PPO plans, Aetna Whole Health Managed Choice Open Access plans and Aetna Indemnity plans are underwritten by Aetna Life Insurance Company. Aetna Dental plans are underwritten 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 F.** Please use only black ink to complete this form.

Group number
Aetna member ID number (if available)

Company name:

Effective date / **Date of hire**			
	☐ New hire ☐ Rehire / reinstatement ☐ New group enrollment ☐ Late enrollment ☐ Waiver ☐ Open enrollment ☐ Loss of coverage	☐ Add spouse ☐ Add domestic partner ☐ Add civil union partner ☐ Add dependent child ☐ Change of coverage ☐ Name change	☐ Employee termination date: _____ ☐ Remove spouse ☐ Remove domestic partner ☐ Remove civil union 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
Work address		City, state	ZIP code
Home telephone ( ) -	Work telephone ( ) -	Primary language spoken (optional)	Number of dependents, including spouse or domestic partner or civil union partner, enrolling for medical coverage

Salary (if enrolling for life or disability coverage) $ _____	☐ Hourly ☐ Weekly ☐ Monthly	Number of hours worked a week	Check one: ☐ Full time ☐ Part time ☐ 1099 ☐ Retiree ☐ Seasonal ☐ Temporary ☐ COBRA ☐ Union

B. Coverage selection *(Top boxes for employer and Aetna use only)*

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

1. Medical ☐ Yes ☐ No *Check one (if applicable)*

☐ Open Choice PPO – Plan option _____

☐ Aetna Whole Health Managed Choice Open Access – Plan option _____

☐ Indemnity (only available if PPO networks are not available) – Plan option _____

☐ Other Plan – 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 _____

For FOC, choose: ☐ DMO® or ☐ PPO

Voluntary plans – Plan number _____ Plan name _____

For FOC, choose: ☐ DMO® or ☐ PPO

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

Aetna Vision℠ Preferred ☐ Yes ☐ No

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	Dental provider office ID number	Current patient ☐ Yes

2	☐ Add ☐ Change ☐ Remove	**Name** (Last, first, middle initial) ☐ **Spouse** ☐ **Domestic partner** ☐ **Civil union partner**	Sex (M/F)	Social Security number
Birthdate (MM/DD/YYYY) / /	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision			
PCP provider ID number	Current patient ☐ Yes	Dental provider office 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) / /	Incapacitated ☐ Yes ☐ No	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision		
PCP provider ID number	Current patient ☐ Yes	Dental provider office 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) / /	Incapacitated ☐ Yes ☐ No	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision		
PCP provider ID number	Current patient ☐ Yes	Dental provider office ID number	Current patient ☐ Yes	

Continued on next page

C. Individuals covered *(Continued)*

5	☐ Add ☐ Change ☐ Remove	**Name** (Last, first, middle initial)	☐ **Child** ☐ **Stepchild** ☐ **Other** _____	Sex (M/F)	Social Security number
Birthdate (MM/DD/YYYY) / /		Incapacitated ☐ Yes ☐ No		Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision	
PCP provider ID number		Current patient ☐ Yes		Dental provider office 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) / /		Incapacitated ☐ Yes ☐ No		Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision	
PCP provider ID number		Current patient ☐ Yes		Dental provider office ID number	Current patient ☐ Yes

D. Dependent information

List any dependent in Section **C** with a different last name or 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. 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 / civil union partner:	☐ Medical ☐ Vision	☐ Dental
☐ Child(ren):	☐ Medical ☐ Vision	☐ Dental

Reason for declining coverage

- ☐ Parental group coverage
- ☐ Spouse / domestic partner / civil union 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:

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	

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, Aetna Whole Health Managed Choice Open Access and Aetna Indemnity 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. Even if this enrollment form is approved, any misstatements or omissions may result in future claims being denied and the policy or my coverage under the policy being rescinded or reevaluated, as of the effective date, for eligibility and rating purposes, subject to the Connecticut Incontestability clause with a 2 year limit on information in this application.
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, substance abuse and HIV / 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 / civil union partner / 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 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. 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® 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.
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. In Connecticut, DMO plans provide out-of-network benefits. However, in order to receive maximum benefits, members must select and have care coordinated by a participating primary care dentist. Connecticut DMO is not an HMO.

Misrepresentation

7. Any person who knowingly and with intent to defraud 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.

To the best of my knowledge and belief, 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 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 at the regular place of business and I am working full time at least 30 hours a week (or 20 hours a week if my employer extends coverage). I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments required for coverage.

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)*

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FAMILY HEALTH STATEMENT

CHECK ONE: New Group ☐ New Employee Add ☐ Existing Employee Change ☐

PRINT IN INK----COMPLETE BOTH SIDES OF FORM

Information provided on this form will have no effect on nor be considered when calculating premiums and/or cost sharing and will not affect your eligibility for coverage. This information is provided so that your health insurance plan can better manage potential adverse health issues and assist you in preventing or managing chronic health conditions you may have or which you may have the potential of developing.

TO BE COMPLETED BY EMPLOYER

NAME OF EMPLOYER:	EMPLOYER ADDRESS: Street:
POLICY NUMBER	City:
	ST/Zip:

APPLICANT'S OCCUPATION	HOURS WORKED/WEEK	DATE OF FULL TIME HIRE

TO DECLINE COVERAGE -- EMPLOYEE IS TO COMPLETE THIS AREA

( ) I **DECLINE** TO ENROLL FOR HEALTH COVERAGE DUE TO THE EXISTENCE OF OTHER GROUP HEALTH COVERAGE
FOR: MYSELF ( ) SPOUSE ( ) DEPENDENT CHILDREN ( )

SIGNATURE OF EMPLOYEE: **DATE:**

TO REQUEST COVERAGE--ANSWER ALL QUESTIONS

IF ADDITIONAL SPACE IS NEEDED, ATTACH SEPARATE SHEET -- COMPLETE FOR ALL FAMILY MEMBERS APPLYING FOR COVERAGE

FIRST NAME INITIAL LAST NAME	HEIGHT	WEIGHT	DATE OF BIRTH MM/DD/YYYY	SEX M/F	FULL TIME STUDENT Yes/No--If yes, Name School
EMPLOYEE:					
SPOUSE:					
CHILD(REN)					

EMPLOYEE SOCIAL SECURITY NUMBER:	MARITAL STATUS: ( ) SINGLE ( ) MARRIED
EMPLOYEE ADDRESS: Street:	PHONE: WORK ( ) - HOME ( ) -
City: ST/Zip:	WHERE WOULD YOU PREFER TO BE CALLED DURING THE DAY? HOME ( ) WORK ( )

I hereby represent and agree that all the answers and statements in this request are full, complete and true, to the best of my knowledge and belief.

DATE:_____ **Employee Signature:** _____ **Spouse Signature:**_____

OTHER SIDE MUST BE COMPLETED

EMPLOYER NAME:_____
(please print)

ARE YOU NOW ACTIVELY AT WORK FULL TIME (30+ HRS/WEEK)? ( ) YES ( ) NO
ARE YOU NOW ACTIVELY AT WORK 20-29 HRS/WEEK? ( ) YES ( ) NO
DOES YOUR SPOUSE HAVE MEDICAL COVERAGE ELSEWHERE? ( ) YES ( ) NO
IS ANY PERSON TO BE INSURED CURRENTLY COVERED UNDER COBRA? ( ) YES ( ) NO
IS ANY PERSON TO BE INSURED ENROLLED IN MEDICARE? ( ) YES ( ) NO
IF YES, WHO:_____ ( ) MEDICARE A ( ) MEDICARE B

TO REQUEST COVERAGE--ANSWER ALL QUESTIONS DETAILS MAY BE SUBMITTED VIA SEALED ENVELOPE MARKED "CONFIDENTIAL"
FOR "YES" ANSWERS, DETAILS MUST BE PROVIDED *IF ILLNESS IS UNLISTED, PROVIDE DETAILS IN THE ROW MARKED "OTHER"*

		YES	NO
1.	Are you, your spouse, or any dependent to be insured, currently disabled or unable to perform their normal activities? WHO: WHY:		
2.	Have you, or any dependent, been hospitalized, or been advised to be hospitalized within the past 5 years for any reason? WHO: WHY:		
3.	Have you, or any dependent, had surgery, or been advised to have surgery within the past 5 years for any reason? WHO: WHY:		
4.	Are you, or any dependents to be covered, currently pregnant? WHO: EXPECTED DELIVERY DATE:		
5.	Is this pregnancy the result of infertility treatment? Please explain:		
6.	Are you, or any dependents to be covered, currently taking any medication? WHO:_____ MEDICATION:_____ WHY:_____		
7.	Have you, or any dependent, had medical expenses in excess of $5,000.00 in the last 12 months? WHO: WHY:		

8. Have you, or any dependent ever had, or has a Medical Professional told, counseled, or treated, you or any dependent, for any of the following?
In answering this question, you should not include any genetic information. Please do not include any family medical history information (other than the specific information requested below) or any information related to genetic services or genetic diseases for which you believe you may be at risk.

	YES	NO	Person Affected	Diagnosis & Date Diagnosed	Treatment And/or Medication	Degree of Recovery	Name, Address & Phone Number of Physician and/or Hospital
a) Chest Pain, Heart Attack, or other heart condition							
b) Condition/Disease of the circulatory system (i.e. blood vessels, phlebitis, leg ulcers)							
c) Cancer, tumor, or lymph node enlargement (indicate type of cancer and location)							
d) Acquired Immuno Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)							
e) High Blood Pressure (if yes, provide most recent reading)							
f) Diabetes or disorder of endocrine system or glands (indicate if insulin dependent)							
g) Alcohol or drug use, abuse, and/or dependency							
h) Disease of the kidney, bladder or urinary tract							
i) Crohns, Colitis, diseases of stomach, intestine, esophagus or gallbladder							
j) Disorder of the liver or pancreas							
k) Disorder of the lungs or respiratory system							
l) Organ Transplants (if yes, include type and date)							
m) Neurologic problems--disorder of the brain, seizures, epilepsy, central nervous system--stroke or paralysis							
n) Nervous, mental, depression, stress or anxiety related disorder, eating disorder							
o) Disorder of the blood (including anemia)							
p) Lupus or Arthritis (if yes, indicate type and severity of disability)							
q) Congenital anomalies or disorders							
r) OTHER (any disease/condition not listed above)							