

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.



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

Member Aetna ID Number (if available) _____

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 G.					
Effective Date	<input type="checkbox"/> New Hire <input type="checkbox"/> Rehire/Reinstatement <input type="checkbox"/> Late Enrollment <input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Waiver <input type="checkbox"/> Other	<input type="checkbox"/> Change of coverage <input type="checkbox"/> Add Spouse/Dependent Child <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 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 _____		

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

Social Security Number	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	No. of Hours Worked Per Week	Check One <input type="checkbox"/> Part-Time <input type="checkbox"/> Full-Time	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	No. of Dependents Including Spouse

B. 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.

1. Medical Coverage Declined for: <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents	Reason for Declining Coverage (if applicable, please attach front/back of your health coverage ID card.): <input type="checkbox"/> Covered by spouse's group coverage - Carrier Name and ID: _____ <input type="checkbox"/> Enrolled in other Insurance Carrier Plans - Carrier Name and ID: _____
2. Dental Coverage Declined for: <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents	<input type="checkbox"/> Spouse covered by employer's group medical coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Covered by TRICARE or CHAMPVA <input type="checkbox"/> Spouse covered by employer's group dental coverage <input type="checkbox"/> Other (Explain): _____

I acknowledge 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 other than an HMO plan, may not be covered for twelve months.

Please sign here ONLY if you are declining coverage for yourself or dependent(s). _____ **Date (Month/Day/Year)** _____

Employee Signature

C. Coverage Selection - Please print clearly, using black ink. (Top boxes 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. PA POS: <input type="checkbox"/> Plan 1.2 <input type="checkbox"/> Plan 2.2 <input type="checkbox"/> Plan 3.2 <input type="checkbox"/> Plan 4.2 <input type="checkbox"/> Plan 5.2 <input type="checkbox"/> Plan 6.2 <input type="checkbox"/> Plan 7.2 PA POS No Referral: <input type="checkbox"/> Plan 1.2 <input type="checkbox"/> Plan 2.2 <input type="checkbox"/> Plan 3.2 <input type="checkbox"/> Plan 4.2 <input type="checkbox"/> Plan 5.2 <input type="checkbox"/> Plan 6.2 <input type="checkbox"/> Plan 7.2 PA POS HSA Compatible No Referral: <input type="checkbox"/> Plan 3.2 <input type="checkbox"/> Plan 4.2 <input type="checkbox"/> Plan 5.2 <input type="checkbox"/> Plan 6.2 PA POS Cost Sharing: <input type="checkbox"/> Plan 3.2 <input type="checkbox"/> Plan 4.2 <input type="checkbox"/> Plan 5.2 PA POS Cost Sharing No Referral: <input type="checkbox"/> Plan 4.2 <input type="checkbox"/> Plan 5.2 PA PPO: <input type="checkbox"/> Plan 1.1 <input type="checkbox"/> Plan 2.1 <input type="checkbox"/> Plan 3.1 PA POS HSA Compatible: <input type="checkbox"/> Plan 1.1 <input type="checkbox"/> Plan 2.1 <input type="checkbox"/> Plan 3.1 <input type="checkbox"/> PA PPO Basic Hospital Plan 1.1 <input type="checkbox"/> PA Health Network Option AHF HRA Plan 1.1 <input type="checkbox"/> Other Plan _____]					2. [Dental - Check one. Contributory Options: <input type="checkbox"/> Option 2 DMO <input type="checkbox"/> Option 3 Freedom of Choice: <input type="checkbox"/> DMO or <input type="checkbox"/> PPO <input type="checkbox"/> Option 4 PPO Max <input type="checkbox"/> Option 5 Active PPO - High Option <input type="checkbox"/> Option 6 Passive PPO 1500 <input type="checkbox"/> Option 7 Consumer Directed Dental Fund <input type="checkbox"/> Out-of-State Situs Voluntary Options: <input type="checkbox"/> Option V2 DMO <input type="checkbox"/> Option V3 Freedom of Choice: <input type="checkbox"/> DMO or <input type="checkbox"/> PPO <input type="checkbox"/> Option V4 PPO Max <input type="checkbox"/> Option V7 Consumer Directed <input type="checkbox"/> Out-of-State/Situs					3. [Life and Disability <input type="checkbox"/> Basic Life/AD&D Ultra™ <input type="checkbox"/> Optional Dependent Life <input type="checkbox"/> Life & Disability Packaged Plan] Beneficiary Designation - Full Name (First, Middle, Last) _____ Beneficiary Social Security Number _____ Relationship to Employee _____		

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

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

Name (Last, First, M.I.)	Sex M/F	Social Security Number	Birthdate (MM/DD/YYYY)	Height (ft., in)	Weight (lbs)	Incapacitated	Coverage Election	Other Health Coverage	Other Dental Coverage	Prior Dental Coverage	Student Age 19 or Older	Out of Area	Aetna Primary Office ID Number (if applicable)	Current Patient	Dental Office ID Number (if applicable)	Current Patient
Employee 1.						Yes N/A	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life/Dis	Yes	Yes	Yes	Yes	Yes		Yes		Yes
Spouse 2.						N/A	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life				N/A					
Child 3.							<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life									
Child 4.							<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life									
Child 5.							<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life									

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.)	Child <input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02 3. <input type="checkbox"/> Hispanic or Latin – 03 <input type="checkbox"/> Asian – 04 <input type="checkbox"/> Other – 05 _____
Employee <input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02 1. <input type="checkbox"/> Hispanic or Latin – 03 <input type="checkbox"/> Asian – 04 <input type="checkbox"/> Other – 05 _____	Child <input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02 4. <input type="checkbox"/> Hispanic or Latin – 03 <input type="checkbox"/> Asian – 04 <input type="checkbox"/> Other – 05 _____
Spouse <input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02 2. <input type="checkbox"/> Hispanic or Latin – 03 <input type="checkbox"/> Asian – 04 <input type="checkbox"/> Other – 05 _____	Child <input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02 5. <input type="checkbox"/> Hispanic or Latin – 03 <input type="checkbox"/> Asian – 04 <input type="checkbox"/> Other – 05 _____

F. Dependent Information

Does any dependent listed in Section C live at another address? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, who and what address? _____	If any dependent's last name differs from yours, explain the circumstances. _____
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G. Other Insurance

Does anyone enrolling on this enrollment form have prior coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide information requested in the grid below.
If you are age 65 or older, are you eligible and enrolled for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide the effective date: ____ / ____ / ____ (month/day/year) and check the applicable boxes: <input type="checkbox"/> Part A <input type="checkbox"/> Part B

Proof of coverage must accompany this enrollment form for pre-existing condition credit 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
					<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. Mandatory Health Questionnaire for Groups Enrolling 2 – 19 Employees.

Any employee requesting Basic Life Benefits greater than the Guaranteed Issue Level must also complete the Health Questionnaire below.

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, blood vessels or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>
2. Ulcer, colitis, gallstones or any other disorder of the stomach, intestines, rectum, pancreas, liver or Hepatitis B/C?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Cancer, cyst or tumor?.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Disorders of the kidneys, adrenal glands, thyroid gland, urinary system, male or female organs, infertility, menstrual dysfunction or sexually transmitted disease (except AIDS/ARC)?.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Asthma, emphysema, tuberculosis or any other disorders of the lungs or respiratory system?.....	<input type="checkbox"/>	<input type="checkbox"/>
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)	<input type="checkbox"/>	<input type="checkbox"/>
7. Lupus, arthritis, back trouble or any other disorder of the joints, muscles or bones, including prosthetic device or implants?.....	<input type="checkbox"/>	<input type="checkbox"/>
8. Any physical deformity, defect or congenital problem?.....	<input type="checkbox"/>	<input type="checkbox"/>
9. Has any person to be covered had or has been told they have an immune disorder, AIDS, or AIDS-Related Complex?	<input type="checkbox"/>	<input type="checkbox"/>
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?.....	<input type="checkbox"/>	<input type="checkbox"/>
11. Has any person been diagnosed with diabetes? If Yes, list date of diagnosis: ____ / ____ / ____ (month/day/year)..... <input type="checkbox"/> Insulin dependent <input type="checkbox"/> Non-insulin dependent	<input type="checkbox"/>	<input type="checkbox"/>
12. a. Is any female to be covered currently pregnant? If Yes, list due date: ____ / ____ / ____ (month/day/year)	<input type="checkbox"/>	<input type="checkbox"/>
b. Have there been any complications thus far?	<input type="checkbox"/>	<input type="checkbox"/>
c. Are multiple births expected?	<input type="checkbox"/>	<input type="checkbox"/>
13. 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?	<input type="checkbox"/>	<input type="checkbox"/>
14. Has any applicant taken any prescribed medications in the past 12 months? If Yes, list on the next page.	<input type="checkbox"/>	<input type="checkbox"/>
15. Has any applicant had an abnormal physical exam or been advised to undergo further testing, surgery or treatment?	<input type="checkbox"/>	<input type="checkbox"/>
16. Has any applicant been a patient in a hospital, clinic, surgical center, sanatorium or medical facility as an outpatient or inpatient (excluding childbirth)?	<input type="checkbox"/>	<input type="checkbox"/>
17. Does anyone on this enrollment form use tobacco products, including cigarettes, pipe, cigar, or chewing tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, check applicable boxes: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse		
18. Has any applicant had any medical condition or symptom not listed on this enrollment form?.....	<input type="checkbox"/>	<input type="checkbox"/>

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS ABOVE (EXCEPT QUESTION 9) 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.

I. Mandatory Health Questionnaire for all groups of 20 - 50 Employees in the state of Pennsylvania – except EMPLOYER GROUPS LOCATED IN SOUTHEAST PA (Philadelphia, Bucks, Montgomery, Chester, Delaware, Berks, Lehigh, Northampton, Carbon and Monroe Counties). Employer groups in these counties do NOT need to complete this section.

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, have you, your spouse or any of your dependents:

Yes No

- Had, consulted for, had treatment rendered, been advised to have treatment or been hospitalized for any of the following: Cardiovascular disease or heart attack, stroke; disorder of the kidneys, stomach, intestines or liver; musculoskeletal conditions; mental or nervous condition; central nervous system disorder; diabetes; any disorder of the lungs or respiratory system; cancer or immune deficiency disorder (except HIV), AIDS, or AIDS-Related Complex?
 - Have you or any dependents to be covered visited a health care professional for any illness and/or medical condition resulting in medical expenses of more than \$5,000 in the past 24 months?.....
 - Have you or any dependent to be covered been advised in the last 12 months that hospitalization, surgery or treatment is needed or pending?
 - a. Is any female to be covered currently pregnant?
 - b. 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?
 - Does anyone listed on this enrollment form use tobacco products, including cigarettes, pipe, cigar, or chewing tobacco?
- If Yes, check applicable boxes. Employee Spouse

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

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

J. Health Questionnaire - Details for "Yes" Responses in Sections H & I.

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS IN SECTIONS H & I, YOU MUST COMPLETE THE FOLLOWING.

Please provide us with FULL DETAILS for each "Yes" answer to any condition(s) checked in Sections H & 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.)*

Question Number	Name of Individual	Condition/Diagnosis	Date of Onset	Date Treatment Ended	Medication Prescribed	Dosage	Still Taking Medication
							<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
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							<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

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, 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 HMO plans and Aetna POS plans: Aetna Health Inc. and/or Aetna Health Insurance Company
 - Aetna PPO plans: Aetna Life Insurance Company
 - Life, Accidental Death & Dismemberment, disability, dental and all other 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 the employer application have been accepted and approved by Aetna. Even if this enrollment form is approved, any intentional and material misstatements or omissions that amount to fraud, or which would have affected the carrier's rating, offering or issuing of coverage impacted, 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. Failure to disclose all health information encompassed by the questionnaire will be deemed to be material omissions for rating purposes.

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.
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"), including pharmacies and 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 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 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 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 12 months.

Misrepresentation

8. Any person who knowingly and with intent to defraud any insurance company or other person files an enrollment form 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 to the best of my knowledge and belief. I have read and agree to the Conditions of Enrollment and Misrepresentation on this **Pennsylvania** Small Group Business (2-50 Eligible Employees) 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.

<i>Employee Signature</i> X	<i>Spouse Signature</i> X	<i>Employee E-mail Address (optional)</i>	<i>Date (Month/Day/Year)</i>
<i>Employer Signature</i> X			<i>Date (Month/Day/Year)</i>