



Arizona 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 I.**

Effective Date	<input type="checkbox"/> New Hire	<input type="checkbox"/> Late Enrollment	<input type="checkbox"/> Change of Coverage	<input type="checkbox"/> Employee Termination	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 _____ Reason _____
Date of Hire	<input type="checkbox"/> Rehire/Reinstatement	<input type="checkbox"/> Other _____	<input type="checkbox"/> Add Spouse/Dependent Child	<input type="checkbox"/> Remove Spouse/Dependent Child	
	<input type="checkbox"/> New Group Enrollment		<input type="checkbox"/> Name Change	<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. <input type="checkbox"/> HMO \$15/\$30/\$250 <input type="checkbox"/> HMO+ (QPOS): <input type="checkbox"/> \$10/\$20/\$0 <input type="checkbox"/> \$15/\$30/\$250 <input type="checkbox"/> \$20/\$40/\$500 <input type="checkbox"/> CPOS: <input type="checkbox"/> \$250 90/70 <input type="checkbox"/> \$500 90/70 <input type="checkbox"/> \$250 80/60 <input type="checkbox"/> \$500 80/60 <input type="checkbox"/> \$750 80/60 <input type="checkbox"/> \$1,000 70/50 <input type="checkbox"/> \$1,500 70/50 <input type="checkbox"/> CPOS (HSA Compatible) HDHP \$2,500 80/50 <input type="checkbox"/> PPO: <input type="checkbox"/> \$500 90/70 <input type="checkbox"/> \$500 80/60 <input type="checkbox"/> \$500 80/50/50 <input type="checkbox"/> \$750 80/60 <input type="checkbox"/> \$1,000 70/50 <input type="checkbox"/> Basic Plus \$1,500 <input type="checkbox"/> PPO (HSA Compatible): <input type="checkbox"/> HDHP \$2,100 100/50 <input type="checkbox"/> HDHP \$2,650 80/50 <input type="checkbox"/> Indemnity \$500 80% <input type="checkbox"/> Out-of-State: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000					2. Dental - Check one. <input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2: <input type="checkbox"/> DMO or <input type="checkbox"/> PPO <input type="checkbox"/> Option 3 <input type="checkbox"/> Option 4 <input type="checkbox"/> Option 5 <input type="checkbox"/> Out-of-State Before today, were you covered under this employer's dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No					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 No. _____ Relationship to Employee _____				

B. 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 (optional) \$	<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"/> Married <input type="checkbox"/> Single	No. of Dependents Excluding Self

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

(Add/Change/Remove)	Name (Last, First, M.I.)	Sex M/F	Social Security No.	Birthdate MM / DD / YYYY	Height (ft., in.)	Weight (lbs.)	Incapacitated	Coverage Election	Other Health Coverage	Other Dental Coverage	Prior Dental Coverage	Age 19 or Older	Primary Office ID Number (If applicable)	Current Patient	Dental Office ID Number (If applicable)	Current Patient
Employee	1.			/ /			Yes <input type="checkbox"/> N/A <input type="checkbox"/>	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/> N/A <input type="checkbox"/>		Yes <input type="checkbox"/>		Yes <input type="checkbox"/>
Spouse	2.			/ /			N/A <input type="checkbox"/>	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A <input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Child	3.			/ /			<input type="checkbox"/>	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Child	4.			/ /			<input type="checkbox"/>	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>

D. Dependent Information

Does any dependent listed in Section C live at another address? Yes No
If Yes, who and what address? _____

If any dependent's last name differs from yours, explain the circumstances. _____

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.)

Employee <input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02 1. <input type="checkbox"/> Hispanic or Latino - 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 3. <input type="checkbox"/> Hispanic or Latino - 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 Latino - 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 Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____

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.

F. Other Insurance

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

If you are age 65 or older, are you eligible and enrolled for Medicare? Yes No
 If Yes, provide the effective date: ____/____/____ (month/day/year) and check the applicable boxes: Part A Part B

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

G. Health Questionnaire for Groups Enrolling 2 - 25 Employees (and employees of groups enrolling 26-50 Employees who are requesting Basic Life benefits greater than the Guarantee Issue Level.)

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 glands, urinary systems, 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"/>	<input type="checkbox"/>
Insulin dependent? _____ Non-insulin dependent? _____		
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"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
13. Has any applicant taken any prescribed medications in the past 12 months? If yes, list below.	<input type="checkbox"/>	<input type="checkbox"/>
14. Has any applicant had an abnormal physical exam or been advised to undergo further testing, surgery or treatment?	<input type="checkbox"/>	<input type="checkbox"/>
15. 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"/>
16. Does anyone named on this application use tobacco products, including cigarette, pipe, cigar, or chewing tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, check applicable boxes: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse		
17. 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, YOU MUST COMPLETE SECTION H ON THE FOLLOWING PAGE.

If you are providing additional sheets, check here.

H. Health Questionnaire - Details for "Yes" Responses in Section G.

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS IN SECTION G, YOU MUST COMPLETE THE FOLLOWING.

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

Ques. #: [] **Name of Applicant:** _____ **Name of Illness/Condition:** _____
 Date of Onset: Month ____ Year ____ Date Treatment Ended: Month ____ Year ____ Still under Treatment: Yes No
 Medication: _____ Date Prescribed: Month ____ Year ____ Dosage: _____
 Treatment Given: _____

Ques. #: [] **Name of Applicant:** _____ **Name of Illness/Condition:** _____
 Date of Onset: Month ____ Year ____ Date Treatment Ended: Month ____ Year ____ Still under Treatment: Yes No
 Medication: _____ Date Prescribed: Month ____ Year ____ Dosage: _____
 Treatment Given: _____

Ques. #: [] **Name of Applicant:** _____ **Name of Illness/Condition:** _____
 Date of Onset: Month ____ Year ____ Date Treatment Ended: Month ____ Year ____ Still under Treatment: Yes No
 Medication: _____ Date Prescribed: Month ____ Year ____ Dosage: _____
 Treatment Given: _____

Ques. #: [] **Name of Applicant:** _____ **Name of Illness/Condition:** _____
 Date of Onset: Month ____ Year ____ Date Treatment Ended: Month ____ Year ____ Still under Treatment: Yes No
 Medication: _____ Date Prescribed: Month ____ Year ____ Dosage: _____
 Treatment Given: _____

Ques. #: [] **Name of Applicant:** _____ **Name of Illness/Condition:** _____
 Date of Onset: Month ____ Year ____ Date Treatment Ended: Month ____ Year ____ Still under Treatment: Yes No
 Medication: _____ Date Prescribed: Month ____ Year ____ Dosage: _____
 Treatment Given: _____

Ques. #: [] **Name of Applicant:** _____ **Name of Illness/Condition:** _____
 Date of Onset: Month ____ Year ____ Date Treatment Ended: Month ____ Year ____ Still under Treatment: Yes No
 Medication: _____ Date Prescribed: Month ____ Year ____ Dosage: _____
 Treatment Given: _____

Ques. #: [] **Name of Applicant:** _____ **Name of Illness/Condition:** _____
 Date of Onset: Month ____ Year ____ Date Treatment Ended: Month ____ Year ____ Still under Treatment: Yes No
 Medication: _____ Date Prescribed: Month ____ Year ____ Dosage: _____
 Treatment Given: _____

I. Declination/Waiver of Coverage - To be completed if medical, dental or life coverage is declined or refused by an eligible employee and/or their eligible family members.

<p>1. Medical Coverage Declined for: <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents</p> <p>2. Dental Coverage Declined for: <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents</p> <p>3. Coverage Declined for: <input type="checkbox"/> Life/Life & Disability Pkg Plan <input type="checkbox"/> Optional Dependent Life</p>	<p>Reason for Declining Coverage <i>(If applicable, please attach front/back of your health coverage ID card.):</i></p> <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 _____ <input type="checkbox"/> Spouse covered by employer's group medical coverage <input type="checkbox"/> Spouse covered by employer's group dental coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Covered by TRICARE or CHAMPVA <input type="checkbox"/> AHCCCS <input type="checkbox"/> Indian Health Services <input type="checkbox"/> Other (Explain): _____
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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)** _____

X Employee Signature

If you are providing additional sheets, check here.

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 and Aetna POS plan: Aetna Health Inc., Corporate Health Insurance Company and/or Aetna Life Insurance Company
 - Aetna PPO plans: Aetna Life Insurance Company
 - Life, Accidental Death & Dismemberment, disability, dental (except DMO) and all other coverages: Aetna Life Insurance Company. DMO dental coverage is provided by Aetna Health Inc.
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 and the policy or my coverage under the policy being rescinded or reevaluated, as of the effective date, for eligibility and 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 Employer 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 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.
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 Arizona 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.
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 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, 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.
8. I understand and agree that, as described in the plan documents, when enrolled for medical and disability coverage in other than an HMO plan, any pre-existing conditions for my spouse, dependents or myself may not be covered for 12 months.

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 Arizona 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 at the regular place of business.

<i>Employee Signature</i>	<i>Spouse Signature (Optional - required only if enrolling)</i>	<i>Date (Mo./Day/ Yr.)</i>
X	X	