



Enrollment/Change Request

Aetna Life Insurance Company

Employer Group Information: (To Be Completed by Employer)	Employer Name - Full Name of Business or Organization	Control	Suffix	Account	Plan Number
	Employer Address (Street, City, State, ZIP Code) - Primary Location of Business or Organization	Group Number (IMO Only)	Customer Code (Optional)		

A. Type of Activity - Employee Completes Sections A - E. Please Print Clearly.

Instructions: Refer to the instructions on the back before completing this form. You, the employee, must complete this application in full or it will be returned to you resulting in a delay in processing. You are solely responsible for its accuracy and completeness.	Enrollment - Check one. <input type="checkbox"/> New Enrollee/Subscriber Effective Date: / / <input type="checkbox"/> Rehire/Reinstatement Date of Rehire/Reinstatement: / / Date of Hire: / /	Change - Check all that apply. <input type="checkbox"/> Add Spouse <input type="checkbox"/> Add Dependent Child <input type="checkbox"/> Name Change <input type="checkbox"/> Other <input type="checkbox"/> Control/Suffix/Acct/Plan Date of Event: / / Reason: _____	Remove or Terminate - Check all that apply. <input type="checkbox"/> Remove Spouse <input type="checkbox"/> Remove Dependent Child <input type="checkbox"/> Employee Withdrawal/Termination <input type="checkbox"/> Cancel Coverage Effective Date: / / Reason: _____	Continuation of Coverage, i.e., COBRA, State - Not all options are available. Contact Employer for available options. Coverage For: <input type="checkbox"/> Employee <input type="checkbox"/> Dependents Length of Continuation (months): <input type="checkbox"/> 18 <input type="checkbox"/> 36 <input type="checkbox"/> Other _____ <input type="checkbox"/> 29 - Attach disability determination from the Social Security Admin. Date of Loss of Coverage: / / Date of Qualifying Event: / /
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B. Employee Information

Social Security Number	Last Name, First Name, M.I.	Home Telephone () ()	Work Telephone () ()
Employee Status <input type="checkbox"/> Active <input type="checkbox"/> Retired	Home Address	Apt. No.	City, State ZIP Code
Beneficiary Designation - Full Beneficiary Name (First, Middle, Last) If more than one beneficiary, use Special Remarks (Section D).	Social Security Number of Beneficiary	Relationship to Employee	Earnings <input type="checkbox"/> Annually \$ _____ <input type="checkbox"/> Weekly \$ _____ <input type="checkbox"/> Insurance Amount \$ _____ <input type="checkbox"/> Supplemental Life \$ _____ <input type="checkbox"/> AD&D Amount \$ _____

C. Plan Options - Your selection must be offered by your employer.

Check One:

<input type="checkbox"/> Aetna Choice™ POS II	<input type="checkbox"/> Managed Choice® POS
<input type="checkbox"/> Aetna HealthFund™	<input type="checkbox"/> Open Choice® PPO
<input type="checkbox"/> Aetna Open Access™ Elect Choice	<input type="checkbox"/> Traditional Choice®
<input type="checkbox"/> Aetna Open Access™ Managed Choice	<input type="checkbox"/> Aexcel SM
<input type="checkbox"/> Elect Choice® EPO	<input type="checkbox"/> Aexcel SM Plus
	<input type="checkbox"/> Other _____

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage.

Attach sheet to list additional children.

* Provide details for "Yes" responses below.

Check this box if you are refusing coverage for your dependents.

(A)dd (C)hange (R)emove	Name (First, Middle Initial, Last) (Explain difference in last names in Special Remarks.)	Relation Code	Sex M F	Birthdate MM DD YYYY	Social Security Number (If dependent has no SSN, write "None")	Prior Insur. Plan Yes * No	Other Medical Coverage Yes * No	Other Rx Drug Coverage Yes * No	Handi-capped Yes N/A	Student Yes N/A	Primary Medical Office ID Number	Current Patient Yes No	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.) Code Other
		Self	<input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A	N/A		<input type="checkbox"/>	
			<input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	
			<input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	
			<input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	

Using the KEY below, please identify the Race/Ethnicity code for each individual.

KEY:
01 - White
02 - African American or Black
03 - Hispanic or Latino
04 - Asian
05 - Other (Provide race/ethnicity in "Other" column at left)

1. If "Yes" to Prior Insurance Plan and/or Other Medical Coverage above, provide effective dates, name & policy number of insurance carrier, HMO or other source and your Member Identification Number.

3. Does any dependent listed above live at a different address than the employee? If "Yes," who and what address? Yes No

2. If "Yes" to Other Rx Drug Coverage above, provide effective dates, name & policy number of insurance carrier, HMO or other source and your Member Identification Number.

Special Remarks

E. Employee Signature

By checking this box you agree to use Aetna Navigator, Aetna's member self-service website, for all future printed materials.

I certify that all information supplied in this form is true and complete to the best of my knowledge and/or belief. I have read and agree to the Conditions of Enrollment on the reverse side of this Enrollment/Change Request form.	Employee Signature - Required X	Primary Language Spoken
	Date: / / E-Mail Address: _____	