



Enrollment/Change Request

Aetna Global Benefits®

Coverage underwritten by Aetna Life Insurance Company and Aetna Life & Casualty (Bermuda) Ltd.

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A. Transaction Information

EFFECTIVE DATE OF TRANSACTION (MM/DD/YYYY): _____ / _____ / _____

1. Enrollment (Check One): <input type="checkbox"/> New Enrollee Hire Date (MM/DD/YYYY) _____ / _____ / _____ <input type="checkbox"/> Rehired/Reinstatement Date (MM/DD/YYYY): _____ / _____ / _____ <input type="checkbox"/> Return to Work Date (MM/DD/YYYY): _____ / _____ / _____ <input type="checkbox"/> New Dependent(s) See Section D (below)	2. Change: (Check All That Apply) From: _____ To: _____ <input type="checkbox"/> U.S. Social Security/ID Number _____ (Enter in B.2.) <input type="checkbox"/> Control/Suffix-Account Number _____ (Enter in B.3.) <input type="checkbox"/> Plan Number _____ <input type="checkbox"/> Employee Name _____ <input type="checkbox"/> Dependent Name(s) (Enter New Name(s) Below) <input type="checkbox"/> Beneficiary Designation (Enter in C. 10a-c) <input type="checkbox"/> Stop Continuation of Health Coverage (i.e. COBRA) <input type="checkbox"/> Other: _____	3. Termination: (Check All That Apply) <input type="checkbox"/> Termination of Employment – Reason: _____ <input type="checkbox"/> Canceling Coverage – Reason: _____ <input type="checkbox"/> Canceling All Dependent Coverage* – Reason: _____ <input type="checkbox"/> Canceling Specific Dependents' Coverage* – Reason: _____ <input type="checkbox"/> Continue Employee Health Coverage (i.e. COBRA) <input type="checkbox"/> Continue Dependent Health Coverage (i.e. COBRA) *(indicate individuals for which coverage has been cancelled in Section D)
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B. Employer Information (Shaded Areas in Section B Are Assigned By Aetna)

1. Employer Name – Full Name of Business or Organization	2. Control	Suffix	Account	3. Plan Number	4. Group Number (HMO Only) N/A	5. SFO
6. Employer Address (Street, City, State, Zip/Postal Code, Country – Primary Business Location of Business or Organization)	7. Employer Telephone Number (Include Area &/or Country Code, as applicable)		8. Claim Office Code	9. Customer Code (Optional)	10. Network ID	

C. Employee Information Please Print All Information (Shaded Areas in Section C Are Assigned By Employer)

1. Employee U.S. Social Security/ID Number	2a. Employee Name (Last, First, Middle Initial) – Please provide Employee's Legal Name	3. Salutation <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.	4. Employee Status <input type="checkbox"/> Active <input type="checkbox"/> Retired
6. Country of Citizenship	2b. Employee Name – to appear on ID Card and Explanation of Benefits (If Legal Name exceeds allowable 24 characters) Last Name (16 Characters) _____, First Name (7 Characters) _____, Middle Initial (1 Character) _____	5. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
7. Employee's Mailing Address: Address Line 1: _____ Address Line 2: _____ Address Line 3: _____ Address Line 4: _____ City: _____ State: _____ Province: _____ Zip/Postal Code: _____ Country: _____		8. Employee Residence Information <input type="checkbox"/> Same as Address Mailing OR <input type="checkbox"/> Resident Address Different from Mailing Address. (See Below) City: _____ Country: _____	
10a. Beneficiary Designation – Full Beneficiary Name (Last, First, Middle Initial) – if more than one Beneficiary, use Special Remarks	10b. U.S. Social Security Number (as applicable) of Beneficiary	10c. Relationship of Beneficiary to Employee	11. Earnings (in US\$) \$ _____ <input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly
			12. Insurance Amounts (in US\$) <input type="checkbox"/> Life Insurance \$ _____ <input type="checkbox"/> Supplemental Life \$ _____ <input type="checkbox"/> AD&D Amount \$ _____

D. Individuals Covered (List individuals – including yourself – for whom you are electing/changing coverage)

Check this box if you are refusing coverage for your dependents

(A)dd/New (C)hange (R)emove	Relation Code	Name (Last, First, Middle Initial) – explain any differences in last names in Special Remarks	U.S. Social Security Number (if dep has no U.S. SSN, write "None")	Birthdate (MM/DD/YYYY)	Dep Address (if different than employee's)	Prior Insurance Plan	Other Health Coverage	Currently Covered By Medicare	Handi-capped	Student Age 19 or Older	Primary Care Provider ID # Primary Care Provider Name	Prev. Seen
	Self				Not Applicable	Yes* <input type="checkbox"/>	Yes* <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes* N/A	Yes* N/A	ID # _____ Name _____	Yes <input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ID # _____ Name _____	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ID # _____ Name _____	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ID # _____ Name _____	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ID # _____ Name _____	<input type="checkbox"/>

* See the applicable category in Section D of the Instructions page for additional information that may require reporting in the Special Remarks field.

Special Remarks:

E. Acknowledgements – Signatures Required: I have read and agree to the terms of the authorization on Page 3 of this Enrollment/Change Request form. I understand that, in the event I fail to sign this form within 31 days after the above transaction request or that for any reason Aetna does not receive notice of the above transaction within a reasonable time following the event, my and my dependents' eligibility may be affected.

Employee Signature: **X** _____ Date: _____ Employer Signature: **X** _____ Date: _____

Instructions - Instructions are provided only for those fields which are not self-explanatory or for which you may need additional information.

(√) In the area designated "Check The Type of Health Coverage For Which You Are Eligible" in the upper center of the form, check box to confirm coverage requested. "Other Coverage" may include **Life Only, Dental Only, or**, as available under your Plan of Benefits, an alternate Health option such as Managed Choice (POS).

<p>A. Transaction Information <i>Make sure you complete the Effective Date of Transaction in the upper right corner of the form, above Section A2.</i></p> <p><i>Make sure you read Section E. Sign name and date.</i></p>	<p>To Enroll</p> <ul style="list-style-type: none">- Complete Effective Date of Transaction and check appropriate box in Section A, Number 1.- Complete blank fields in Section B (if applicable).- Complete Section C, Numbers 1 through 12.- Complete Section D for all individuals for whom you are electing coverage, including yourself. Complete ALL items for each individual listed.- Complete Primary Care Provider (PCP) ID# and Name - if applicable (Section D).	<p>To Change</p> <ul style="list-style-type: none">- Complete Effective Date of Transaction and check appropriate box in Section A, Number 2.- Complete blank fields in Section B (if applicable) [If the Change impacts the U.S. Social Security/ID Number, Control Suffix Account or Plan Number, the existing/impacted Number should be identified in Section B. The 'new' Number should be entered in the "To" field in the Change section, for the U.S. Social Security/ID Number or in fields B2 or B3, as applicable].- Complete Section C, Numbers 1, 2, and 3.- Indicate change(s) in appropriate Section(s) (B, C, D) and <i>circle</i>. <p>To Terminate</p> <ul style="list-style-type: none">- Complete Effective Date of Transaction and check appropriate box in Section A, Number 3.- Indicate reason for Termination or Cancellation.- Check "All" or "Specific" cancellation of dependent coverage and indicate specific individual(s) in Section D.- Check appropriate box for individuals continuing health coverage. Note: Section D must be completed for all individuals continuing coverage.
<p>B. Employer Information <i>The Group Number (B4), Servicing Field Office (B5), Claim Office Code (B8) and Network ID (B10) are assigned by Aetna.</i></p>	<p>B2. Control, Suffix and Account - If this information is not preprinted, provide the complete Control, Suffix and Account numbers.</p> <p>B3. Plan Number - If this information is not preprinted, refer to the Plan Sheet to determine the correct Plan Number.</p> <p>B9. Customer Code (Optional) - Provide an identifying Customer Code for the employee only if you had elected to provide this information.</p> <p>NOTE: Employer/Benefits Administrator must also complete items C11 and 12 (below).</p>	
<p>C. Employee Information <i>To be completed by the Enrollee; except, items Earnings (C11) and Insurance Amounts (C12) are completed by the Employer/Benefits Administrator.</i></p>	<p>C10. Beneficiary Designation - <i>Full Beneficiary Name (First, Middle and Last)</i>, U.S. Social Security Number (as applicable, otherwise enter "None"), and relationship of the person to whom benefits will be paid in the event of your death.</p> <p>C11. Earnings - Your Benefits Administrator will identify if earnings amounts need to be reported, check the appropriate box, and enter the rounded dollar amount.</p> <p>C12. Insurance Amounts - Your Benefits Administrator will identify if earnings/insurance amounts need to be reported, check the appropriate box, and enter the rounded dollar amount.</p>	
<p>D. Individuals Covered <i>To be completed by the Enrollee.</i></p> <p><i>List only those individuals for whom you are electing/ changing coverage and complete ALL items for each individual listed except completion of PCP ID# and Name are not required for Open Choice PPO and Traditional Choice health plans</i></p>	<ul style="list-style-type: none">- Add/Change/Remove - Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.- Relationship Code - Use ONLY: H=Husband, W=Wife, N=Divorced Spouse, S=Son, D=Daughter, Y=Sponsored Male, X=Sponsored Female. If the dependent is NOT a biological or legally adopted child, please indicate relationship to employee in Special Remarks.- Name - This must be completed for all individuals for whom you are electing or changing coverage. Please complete ALL items in Section D for each individual listed. Attach another form if you are requesting coverage for additional dependents.- Birthdate - Date of birth should include four digit year of birth.* Prior Insurance Plan - Check "Yes" if you are covered under your employer's or other prior insurance plan. NOTE: You must provide the following in Special Remarks: Carrier/Plan Name, effective date of prior coverage, policy/group number, and prior coverage type (i.e., individual or group).* Other Health Coverage - Check "Yes" if you are currently covered by another health insurance plan. NOTE: You must provide the following in Special Remarks: Carrier Name.- Currently Covered by Medicare - Check "Yes" based on employee/dependent(s) age or disabled status.* Handicapped - Check "Yes" if handicapped and financially dependent, provide proof of handicapped status from the attending physician.* Student Age 19 or Older - Defined as: Unmarried dependent child age 19 or older (refer to your Summary Coverage), regularly attends school and depends solely on the enrollee for support. Member Services may request that you provide proof from the educational institution.- Primary Care Provider (PCP) ID#/PCP Name - From the appropriate provider directory, locate the office ID number (if applicable). Indicate office ID number selection on the form. The PCP ID#s and PCP Names are listed in the <i>Provider Directory</i>. Check "Yes" if the PCP has been previously seen.	
<p>E. Acknowledgements <i>Signature required.</i></p>	<ul style="list-style-type: none">- Read the information contained above the space provided for your signature and the Authorization of Enrollee on Page 3 of this form.- Sign and date the form.	

Authorization of Enrollee

Disclosure of Healthcare Information	I authorize any physician, other healthcare professional, hospital, other healthcare institution and my employer to disclose, at any time and to the extent allowed by law, to Aetna Life Insurance Company or an affiliated entity ("Aetna"), information concerning healthcare (including dental) advice, treatment or supplies provided to my spouse or dependents or to myself, including those involving mental health, substance abuse and HIV/AIDS ("healthcare information").
Redisclosure of Healthcare Information	I also authorize Aetna to redisclose the healthcare information to my employer, healthcare professionals and institutions, independent claims administrators, utilization review organizations and reinsurers or other insurers with which Aetna has contracted.
Purpose of Disclosure/Redisclosure	The healthcare information will be used for the coordination of patient care, administration of benefits, quality management and audit of services, and for fulfilling obligations imposed on Aetna by contract or law.
Dependents' Authorization	I have discussed the terms of this authorization with my spouse and competent adult dependents, and I have obtained their consent to the release of their healthcare information pursuant to this authorization.
Insured's Rights	I understand that I may review and offer corrections to the healthcare information, except information about me or my dependents that relates to claims or civil or criminal proceedings involving me or my dependents. I also understand I may revoke this authorization at any time, except to the extent it has been relied on by Aetna or other party. In addition, I understand that I may receive a copy of this authorization and that a copy of this authorization is as valid as the original.
Duration of Authorization	This authorization shall remain valid for the term of this coverage or for so long as allowed by law.
Payroll Deductions and Other Payments	I request the coverage which I have indicated and for which I am eligible. I authorize deductions from my earnings for any contributions required for healthcare coverage, and I agree to make any necessary payments as required for coverage.
Misrepresentations	<p>I understand it is unlawful for me or my dependents to knowingly provide false, incomplete or misleading facts or information to Aetna for the purpose of defrauding or attempting to defraud Aetna. Penalties may include imprisonment, fines, denial of coverage, rescission of benefits, and legal damages.</p> <p>Attention Pennsylvania Residents: 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.</p>
Independent Contractors	Applicant acknowledges that Aetna Life Insurance Company's participating providers, including all participating primary care physicians, are independent contractors and are not agents or employees of Aetna Life Insurance Company or any affiliated Aetna Entity.