

**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.**



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

Life, Accidental Death & Dismemberment, Disability, Aetna Managed Choice, and Aetna PPO plans are underwritten by Aetna Life Insurance Company. Aetna HMO and Aetna POS plans are underwritten by Aetna Health Inc. Dental plans are provided or administered by Aetna Life Insurance Company.

Member Aetna ID Number (if available)

Employer Name		<b>INSTRUCTIONS:</b> 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. <b>If waiving coverage, please complete Section H.</b>			
Effective Date	<input type="checkbox"/> New Hire <input type="checkbox"/> Rehire/ Reinstatement	<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/State Continuation 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 _____	
Date of Hire	<input type="checkbox"/> New Group Enrollment <input type="checkbox"/> Late Enrollment <input type="checkbox"/> Other _____				Reason _____

### 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.
<b>1. Medical</b> - Check one. <input type="checkbox"/> Aetna HMO Open Access – Plan Option _____ <input type="checkbox"/> Aetna HMO Gatekeeper – Plan Option _____ <input type="checkbox"/> Aetna POS Open Access – Plan Option _____ <input type="checkbox"/> Aetna Managed Choice Open Access – Plan Option _____ <input type="checkbox"/> Other – Plan Option _____					<b>2. Dental</b> - Check one. <b>Standard Plans:</b> <input type="checkbox"/> Aetna Dental™ Plan – Plan Option _____ <input type="checkbox"/> Freedom of Choice: <input type="checkbox"/> Managed Dental or <input type="checkbox"/> PPO <input type="checkbox"/> Out-of-State PPO Plan <b>Voluntary Plans:</b> <input type="checkbox"/> Aetna Dental™ Plan – Plan Option _____ <input type="checkbox"/> Freedom of Choice: <input type="checkbox"/> Managed Dental or <input type="checkbox"/> PPO <input type="checkbox"/> Out-of-State PPO Plan <b>Before today, were you covered under this employer's dental plan?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No					<b>3. Life and Disability</b> <input type="checkbox"/> Basic Life/AD&D Ultra® <input type="checkbox"/> Optional Dependent Life <input type="checkbox"/> Short Term Disability <input type="checkbox"/> Life & Disability Packaged Plan Beneficiary Designation - <b>Full Name</b> (First, Middle, Last) _____ Beneficiary Social Security Number _____ 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 \$	<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	No. of Hours Worked Per Week	Check One <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	No. of Dependents Including Spouse

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

**NOTE FOR MEDICAL AND DENTAL COVERAGE:** While the Federal Patient Protection and Affordable Care Act mandates coverage of dependent children up to age 26, your plan may allow coverage beyond age 26. Some exceptions apply. Please refer to your plan documents or contact your benefits administrator.

Name (Last, First, M.I.)	Sex M/F	Social Security Number	Relationship	Birthdate (MM/DD/YYYY)	Height (ft. in)	Weight (lbs)	Status	Coverage Election	PCP Provider ID Number
Employee							<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life/Dis	
			<input type="checkbox"/> Spouse <input type="checkbox"/> Other _____				<input type="checkbox"/> Different Last Name	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	
Child			<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____				<input type="checkbox"/> Different Last Name <input type="checkbox"/> Lives at another address <input type="checkbox"/> Full-Time Student - Life only <input type="checkbox"/> Disabled	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	
Child			<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____				<input type="checkbox"/> Different Last Name <input type="checkbox"/> Lives at another address <input type="checkbox"/> Full-Time Student - Life only <input type="checkbox"/> Disabled	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	

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

**E. 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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**F. Other Insurance**

Does anyone age 19 or over enrolling on this enrollment form have current or prior coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Proof of coverage should accompany this enrollment form for pre-existing condition credit and if an employee is waiving coverage. Acceptable forms of proof are:			Failure to provide Proof of Prior Coverage may subject you or a family member (age 19 or over) 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. <b>NOTE:</b> If your Plan contains a pre-existing conditions provision, the pre-existing conditions exclusion and limitation will not apply to a person under 19 years of age.		
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.					
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

**G. Medicare Information**

Name of Person	Medicare Part A	Medicare Part B	Medicare Part D	Over Age 65	Disability	End-Stage Renal Disease Eff Date
	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**H. Declination/Waiver of Coverage - Check all that apply.**

I understand I am eligible to apply for this coverage through my employer; however, I am waiving coverage as noted below.					Print Employee Name _____	
<input type="checkbox"/> Employee	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Life	<input type="checkbox"/> Disability	<b>Reason for declining coverage</b> (If applicable attach front/back of your health ID card): <input type="checkbox"/> Covered by spouse's group coverage - Carrier Name and ID number: _____	
<input type="checkbox"/> Spouse	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Life		<input type="checkbox"/> Enrolled in other insurance (check applicable box): <input type="checkbox"/> Medicare <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> Military <input type="checkbox"/> Individual <input type="checkbox"/> COBRA <input type="checkbox"/> Retiree <input type="checkbox"/> Other _____	
<input type="checkbox"/> Child(ren)	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Life		<input type="checkbox"/> Carrier Name and ID number: _____ <input type="checkbox"/> Spouse covered by employer's group coverage <input type="checkbox"/> Do Not Want	
I certify I have been given the right to apply for this coverage; however, I am waiving coverage as noted above. 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 this plan, may not be covered for twelve months. <b>NOTE:</b> If your Plan contains a pre-existing conditions provision, the pre-existing conditions exclusion and limitation will not apply to a person under 19 years of age.						
Please sign here <b>ONLY</b> if you are declining coverage for yourself and/or dependent(s).						Date (Month/Day/Year)
X Employee Signature						

**I. Health Questionnaire for Groups Enrolling 2 - 9 Eligible Employees (or 2 - 50 if enrolling for life above the Guarantee Issue amount) and All New Enrollees for Existing Groups with 2-50 Eligible Employees. All new business groups do not need to complete this section if they are eligible to complete the Group Medical Questionnaire.**

**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 or your application will be returned.
- Incomplete applications may delay the effective date of your coverage.

To the best of your knowledge and belief, in the past twenty-four (24) months, has any person listed on the application been diagnosed with, treated for, or had treatment recommended by a licensed member of the medical profession 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"/>

*Continued on next page*

**IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS ABOVE YOU MUST COMPLETE SECTION J ON THE FOLLOWING PAGE.**



## Conditions of Enrollment

On behalf of myself and the dependents listed on the reverse side:

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: Aetna Health Inc.
  - Aetna POS plans: Aetna Health Inc.
  - Life, Accidental Death & Dismemberment, disability, dental and all 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 unless and until both the eligible employee enrollment form and employer applications have been accepted and approved by Aetna.  
**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. For Dependent Life, dependents are eligible from 14 days of age up to their 19<sup>th</sup> birthday, or up to their 23<sup>rd</sup> birthday, if a full-time student.
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 to 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 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.
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 Managed Dental 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. To the best of my knowledge and belief, I represent that all information supplied in this form is true and complete. On behalf of myself and the eligible persons listed herein, I acknowledge that I have read and understand this form in its entirety.

I represent that all information supplied in this form is true and complete. I have read and agree to the Conditions of Enrollment and Misrepresentation on this **Florida** 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.

**Misrepresentation: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.**

Employee Signature	Employee E-mail Address (optional)	Date (Month/Day/Year)
X		