aetna®

AETNA LIFE INSURANCE COMPANY

151 Farmington Avenue
Hartford, CT 06156

New York Small Group Business
Employee Enrollment/Change Form for
Vision, Life, AD&PL, Medical and Dental Coverage

FOR GROUP COVERAGE (1–50 ELIGIBLE EMPLOYEES)

Life, Accidental Death & Personal Loss, DMO® and PPO dental plans, Aetna EPO plans, Aetna Indemnity, Aetna Vision plans and Aetna NYC Community Plan℠ are provided by Aetna Life Insurance Company. For Vision coverage, certain claims administration services are provided by First American Administrators, Inc. and certain network administration services are provided through EyeMed Vision Care, LLC ("EyeMed").

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 E.**

Member Aetna ID Number (if available)

Company Name

Effective Date **Date of Hire** **BWP** ☐ Class 1 ☐ Class 2	☐ New Hire ☐ Rehire/Reinstatement* ☐ New Group Enrollment ☐ Late Enrollment ☐ Waiver ☐ Open Enrollment *Does not apply to Supplemental or Dependent Life Insurance	☐ Add Spouse ☐ Add Domestic Partner ☐ Add Dependent Child ☐ Change of Coverage ☐ Name Change	☐ Employee Termination ☐ Remove Spouse ☐ Remove Domestic Partner ☐ Remove Dependent Child ☐ Cancel Coverage ☐ Other _____

☐ **COBRA** ☐ **Continuation for:** ☐ Employee ☐ Dependent Length of Continuation: ☐ 18 ☐ 36 ☐ Other _____

Qualifying Event _____ Original Qualifying Event Date _____ Loss of Coverage Date _____

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

1. Medical

☐ Open Access Elect Choice® (OAEPO) Plan Option: _____

☐ Open Access Elect Choice® (OAEPO) HSA Compatible Plan Option: _____

☐ Savings Plus Open Access Elect Choice® (OAEPO) Plan Option: _____

☐ NYC Community Plan℠ Plan Option: _____

☐ Indemnity Plan Option: _____

☐ Other Plan Option: _____

Control/Group No.	Suffix	Account	Plan No.

2. Dental

Standard Plans: Option: _____ FOC: ☐ DMO® *or* ☐ PPO

Voluntary Plans: Option: _____ FOC: ☐ DMO® *or* ☐ PPO

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

Creditable coverage is allowed for new members enrolling in voluntary takeover groups. New hires please see below if applicable:
New Hire selecting a Voluntary Plan **and your Aetna plan is a takeover group:** Were you covered for 12 months under a dental plan within the last 90 days that included both Preventive and Basic coverage? Discount dental and preventive-only plans do not apply. ☐ Yes ☐ No

Control/Group No.	Suffix	Account	Plan No.

3. Life and Disability

Life /AD&PL for groups with 2-9 employees *Check applicable boxes.*

☐ **Employee** ☐ Basic Life/AD&PL Ultra

Life /AD&PL for groups with 10-50 employees *Check applicable boxes.*

☐ **Employee** ☐ Basic Life/AD&PL Ultra ☐ Supplemental Life

☐ **Spouse** ☐ Optional Dependent Life

☐ **Child** ☐ Optional Dependent Life

A. Coverage Selection *(Continued)*

DESIGNATION OF BENEFICIARY – Carefully review Additional Conditions and Instructions for Designation of Beneficiary on Page 5.

Life Products require the employee to designate a beneficiary for benefits. A beneficiary is the person or entity who will receive the benefit payment. A primary beneficiary will be the first to receive the benefit. A contingent beneficiary will only receive the benefit payment if the primary beneficiary dies or is no longer available. The employee is automatically the primary beneficiary for dependent life and AD&PL benefits.

Beneficiary For:	**Full Name(s) or Entity (Trust or Estate)**	**Date of Birth**	**Social Security Number / Tax ID Number**	**Address** (Number, Street, Apt. No., City, State, ZIP Code)	**Phone**	**Relationship to Employee**	**% of Benefit** (must equal 100%)
Basic Life Primary							
Basic Life Contingent							
Supplemental Life Primary							
Supplemental Life Contingent							

SPOUSAL CONSENT FOR COMMUNITY PROPERTY STATES – See Additional Conditions and Instructions for Designation of Beneficiary Section on Page 5.

Please note that an Employee is under no obligation to complete the Spousal Consent section on this form.

I am aware that my spouse, the Employee named above, has designated someone other than me to be the beneficiary of group Life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.

Spouse Signature _____ **Date** _____

Disability – *Check applicable box.* ***Employee only***

Long Term Disability for groups with 10-50 employees ☐ Yes ☐ No

Control/Group No.	Suffix	Account	Plan No.

4. Vision (if applicable)

Aetna Vision Preferred ☐ Yes ☐ No *Check applicable box.*

B. Employee Information - *Must be completed by the employee.*

Last Name, First Name, M.I.			Job Title
Home Address	Apt. No.	City, State	ZIP Code
Work Address		City, State	ZIP Code

Home Telephone	Work Telephone	Primary Language Spoken (Optional)	Number of Dependents (including Spouse/ Civil Union/Domestic Partner) enrolling for medical coverage
( ) -	( ) -		

Salary $ _____	☐ Hourly ☐ Monthly ☐ Weekly	No. of Hours Worked Per Week	Check One ☐ Full-Time ☐ Part-Time ☐ 1099 ☐ Retired ☐ Seasonal ☐ Temporary ☐ Union ☐ COBRA

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

1	**Employee Name** (Last, First, M.I.)	Sex (M/F)	**Social Security Number**	**Birthdate** (MM/DD/**YYYY**) / /	
Coverage Election ☐ Medical ☐ Dental ☐ Life ☐ Vision ☐ Disability	Out of Area **N/A**	Student (Life Only) **N/A**	Dental Office ID Number *(if applicable)*	Current Patient **Yes** ☐	
Primary Office ID Number *(if applicable)*	Physician First & Last Name		Provider ID Number (*if applicable*)	Current Patient **Yes** ☐	
2	**Spouse/Domestic Partner** (Last, First, M.I.)	Sex (M/F)	**Social Security Number**	**Birthdate** (MM/DD/**YYYY**) / /	
Coverage Election ☐ Medical ☐ Dental ☐ Life ☐ Vision	Out of Area **N/A**	Student (Life Only) **N/A**	Dental Office ID Number *(if applicable)*	Current Patient **Yes** ☐	
Primary Office ID Number *(if applicable)*	Physician First & Last Name		Provider ID Number (*if applicable*)	Current Patient **Yes** ☐	
3	**Child** (Last, First, M.I.)	Sex (M/F)	**Social Security Number**	**Birthdate** (MM/DD/**YYYY**) / /	
Coverage Election ☐ Medical ☐ Dental ☐ Life ☐ Vision	Out of Area **Yes** ☐	Student (Life Only) **Yes** ☐	Dental Office ID Number *(if applicable)*	Current Patient **Yes** ☐	Incapacitated Yes ☐ No ☐
Primary Office ID Number *(if applicable)*	Physician First & Last Name		Provider ID Number (*if applicable*)	Current Patient **Yes** ☐	
4	**Child** (Last, First, M.I.)	Sex (M/F)	**Social Security Number**	**Birthdate** (MM/DD/**YYYY**) / /	
Coverage Election ☐ Medical ☐ Dental ☐ Life ☐ Vision	Out of Area **Yes** ☐	Student (Life Only) **Yes** ☐	Dental Office ID Number *(if applicable)*	Current Patient **Yes** ☐	Incapacitated Yes ☐ No ☐
Primary Office ID Number *(if applicable)*	Physician First & Last Name		Provider ID Number (*if applicable*)	Current Patient **Yes** ☐	
5	**Child** (Last, First, M.I.)	Sex (M/F)	**Social Security Number**	**Birthdate** (MM/DD/**YYYY**) / /	
Coverage Election ☐ Medical ☐ Dental ☐ Life ☐ Vision	Out of Area **Yes** ☐	Student (Life Only) **Yes** ☐	Dental Office ID Number *(if applicable)*	Current Patient **Yes** ☐	Incapacitated Yes ☐ No ☐
Primary Office ID Number *(if applicable)*	Physician First & Last Name		Provider ID Number (*if applicable*)	Current Patient **Yes** ☐	
6	**Child** (Last, First, M.I.)	Sex (M/F)	**Social Security Number**	**Birthdate** (MM/DD/**YYYY**) / /	
Coverage Election ☐ Medical ☐ Dental ☐ Life ☐ Vision	Out of Area **Yes** ☐	Student (Life Only) **Yes** ☐	Dental Office ID Number *(if applicable)*	Current Patient **Yes** ☐	Incapacitated Yes ☐ No ☐
Primary Office ID Number *(if applicable)*	Physician First & Last Name		Provider ID Number (*if applicable*)	Current Patient **Yes** ☐	

D. Dependent Information

List any dependent in Section **C** living at another address.

Name	Address

E. Declination/Waiver of Coverage – ***To be completed if coverage is declined or refused by an eligible employee and/or their eligible family members.***

I understand I am eligible to apply for this coverage through my employer; however, I am waiving coverage as noted below.

Employee:	☐ Medical	☐ Dental	
	☐ Life	☐ Vision	☐ Disability
Spouse:	☐ Medical	☐ Dental	
	☐ Life	☐ Vision	
Child(ren):	☐ Medical	☐ Dental	
	☐ Life	☐ Vision	

Reason for Declining Coverage

- ☐ Spousal/Domestic Partner group coverage
- ☐ Parental group coverage
- ☐ COBRA coverage
- ☐ Medicare
- ☐ Medicaid
- ☐ Retiree coverage
- ☐ Another group plan provided by my employer
- ☐ Insurance through another job
- ☐ Individual coverage - On Exchange
- ☐ Individual coverage - Off Exchange
- ☐ TRICARE Military coverage
- ☐ VA Coverage
- ☐ Do not want
- ☐ Other _____

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 I and/or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage.

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

F. Coordination of Benefits

Will you have other health insurance at the same time as this coverage? ☐ Yes ☐ No

Name of Person	Carrier Name	Name of Person	Carrier Name

Conditions of Enrollment

On behalf of myself and the dependents listed, I agree to or with the following:

1. I acknowledge that by enrolling in an Aetna plan(s) on Page 1, coverage is provided by Aetna Life Insurance Company (referred to as "Aetna"). Vision insurance plans are underwritten by Aetna Life Insurance Company (Aetna). Certain claims administration services are provided by First American Administrators, Inc. and certain network administration services are provided through EyeMed Vision Care, LLC ("EyeMed").
2. I understand 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 application have been accepted and approved by Aetna.
   For life coverage: I understand that the effective date of insurance for myself or for any of my dependents is subject to my being active at work on that date. 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. Life insurance may be contested within 2 years from the issue date during the lifetime of the insured based on signed statements made by the insured pertaining to insurability, a copy of which has been given to the insured or the beneficiary. For Dependent Life, dependent children are eligible from birth up to their 26th birthday.
3. I understand and agree that: this enrollment 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 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, excluding drug and alcohol records and psychotherapy notes. 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. This authorization will remain valid no longer than 24 months. 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. This authorization is voluntary. However, I understand that if I refuse to sign this authorization form, my ability to enroll in the medical plans described above may be affected. I have the right to revoke this authorization in writing to Aetna at any time except to the extent that my information has already been used or disclosed in reliance on this authorization. However, because this information is essential to the administration of the plans, I understand that my revocation of this authorization may result in cancellation of my enrollment in the medical plans described above.
4. The plan certificate of coverage will determine the rights and responsibilities of member(s). It 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, 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 dentist or by the participating dentist or other provider as authorized by a referral from a participating primary care dentist.
7. This form is attached to and forms part of the policy and certificate, and may be used to contest the insurance.

continued on next page

Conditions of Enrollment *(Continued)*

8. The validity of individual coverage may be contested within the first two years during the insured's lifetime using written, signed statements made by the insured relating to their insurability with respect to which such statement was made only if a copy has been furnished to the insured or their beneficiary. The policy is incontestable after two years other than non-payment of premiums.
9. **THIS APPLIES ONLY TO ACCIDENTAL DEATH AND PERSONAL LOSS (AD&PL):** I UNDERSTAND THAT THIS IS ACCIDENT-ONLY INSURANCE. IT DOES NOT PROVIDE COVERAGE FOR SICKNESS. THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.
   I ACKNOWLEDGE THAT I HAVE COMPREHENSIVE HOSPITAL, SURGICAL AND MEDICAL HEALTH INSURANCE (MINIMUM ESSENTIAL COVERAGE). ☐ Yes ☐ No
   If you have questions about the benefits provided by this coverage, please contact us at 1-800-523-5065.

Misrepresentation (This fraud warning is not applicable to an application for life insurance.)

10. 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I represent that to the best of my knowledge and belief all information supplied in this form is true and complete. I have read and agree to the Conditions of Enrollment and Misrepresentation on this **New York** Small Group Business (1 – 50 Eligible Employees) Employee Enrollment/Change Form. I understand that if I do not sign this form within 31 days from the date first eligible or 31 days of the qualifying life event (i.e., marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.) I will be considered a late enrollee and the effective date of coverage for me and my dependents may be affected. I am employed by the employer shown on Page 1, and I am working full time at least 20 hours per week for this employer at the regular place of business. I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments as required for coverage.

If you wish to receive documents electronically, please refer to Aetna Navigator® at http://www.aetna.com/individuals-families/aetna-navigator.html.

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

This form is attached to and made a part of the group policy.

Additional Conditions and Instructions for Designation of Beneficiary

Conditions for Designation of Beneficiary

- **Please note:** The Group Contract grants the member the authority to designate a beneficiary. A beneficiary designated by someone other than the member (i.e., attorney-in-fact, Power of Attorney, guardian, custodian, etc.) may be barred under the Group Contract, by the Power of Attorney executed by the member and/or by state law. The member should execute the beneficiary designation section of this form whenever possible to ensure the designation is deemed valid.
- Unless otherwise expressly provided in the Designation of Beneficiary section of this form, if any named beneficiary predeceases me, the life proceeds shall be payable equally to the remaining named beneficiary or beneficiaries. If no named beneficiary survives me, any sum becoming payable under said Group Policy(ies) by reason of my death shall be payable as prescribed in said Group Policy(ies).
- If this Designation of Beneficiary provides for payment to a trustee under a trust agreement, Aetna Life Insurance Company shall not be obliged to inquire into the terms of the trust agreement and shall not be chargeable with knowledge of the terms thereof. Payment to and receipt by the trustee shall fully discharge all liability of said Insurance Company to the extent of such payment.
- If you live in one of the following community property states – Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin – your spouse may have a legal claim for a portion of the life insurance benefit under state law. If you name someone other than your spouse as beneficiary, payment of the death benefit may be delayed until your spouse's claim is resolved.

Instructions for Designation of Beneficiary

If these instructions do not answer all your questions, please contact your plan sponsor for assistance.
Please use only black ink to complete this form.

- If you make a mistake in completing this form, line out the erroneous information, add the correct information and initial the correction. **The printed material on this form should not be deleted or altered in any way.**
- **In all cases**, the relationship of the beneficiary, the beneficiary's Social Security Number, address and phone number should be included with the beneficiary designations.
- **Dollars and cents should not be specified**.
- If a minor child is named beneficiary, the child will not receive the benefits until age of majority.
- If a trustee is named beneficiary, show the exact name of the trust, date of the trust agreement, and the name and address of the trustee. **For example**, The John J. Smith Revocable Life Insurance Trust, dated January 1, 1994. John Smith, Trustee, 123 Apple Lane, Hartford, CT 06006.