# Illinois Small Group Employee Enrollment/Change Form

**Aetna Life Insurance Company** | **Aetna Health Inc.** | **Aetna Health Insurance Company**

| Group number |
|---|
| Aetna member ID number (if available) |

**INSTRUCTIONS:** You must complete this enrollment form in full. If you do not, we will return it to you, and that can delay its processing. You alone are responsible for its accuracy and completeness. **If you are declining coverage, you must complete Section F.** Please use only black ink to complete this form.

**Company name**

| **Effective date** | ☐ New hire<br>☐ Rehire / reinstatement<br>☐ New group enrollment<br>☐ Late enrollment<br>☐ Waiver<br>☐ Open enrollment<br>☐ Loss of coverage | ☐ Add spouse<br>☐ Add civil union partner<br>☐ Add domestic partner<br>☐ Add dependent child<br>☐ Change of coverage<br>☐ Name change | ☐ Employee termination date ________<br>☐ Remove spouse<br>☐ Remove civil union partner<br>☐ Remove domestic partner<br>☐ Remove dependent child<br>☐ Cancel coverage<br>☐ Other ____________ |
|---|---|---|---|
| **Date of hire** | | | |

☐ **COBRA** ☐ **State continuation** for: ☐ Employee ☐ Dependent Length of continuation: ☐ 18 months ☐ 36 months ☐ Other _____
Qualifying event ____________ Original qualifying event date __________ Loss of coverage date __________

## A. Employee information - *You must complete this section.*

| **Social Security number** | Last name, first name, middle initial | | Job title |
|---|---|---|---|
| Home address | Apt. number | City, state | ZIP code |
| Work address | | City, state | ZIP code |
| Home telephone ( ) - | Work telephone ( ) - | Primary language spoken (optional) | Number of hours worked a week |

| Check one<br>☐ Full time ☐ 1099 ☐ Seasonal ☐ COBRA / State continuation<br>☐ Part time ☐ Retiree ☐ Temporary ☐ Union | Number of dependents, including spouse, civil union partner or domestic partner enrolling for medical coverage |
|---|---|

## B. Coverage selection – *Please print clearly. (Top boxes for employer and Aetna use only.)*

| **Control/Group number** | **Suffix** | **Account** | **Plan number** | **Class code** |
|---|---|---|---|---|
| | | | | |

**1. Medical** ☐ Yes ☐ No *To enroll, check one and enter the plan option elected following the plan type below.*

☐ **Quality Point of Service (QPOS)** – Plan option ____________________

☐ **Open Choice® PPO** – Plan option ____________________

*Aetna Life Insurance Company underwrites Aetna Open Choice® PPO plans. Aetna Health Inc. underwrites the in-network portion of Aetna QPOS plans. Aetna Health Insurance Company underwrites the out-of-network portion of Aetna QPOS plans.*

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## B. Coverage selection *(Continued)* – *Please print clearly. (Top boxes for employer and Aetna use only.)*

| Control/Group number | Suffix | Account | Plan number |
|---|---|---|---|
| | | | |

**2. Dental** ☐ Yes ☐ No *To enroll, enter the plan number and name below.*

**Non-voluntary plans** – Plan number ______________ Plan name ____________________

If FOC, choose: ☐ DMO® *or* ☐ PPO

**Voluntary plans** – Plan number ______________ Plan name ____________________

If FOC, choose: ☐ 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

**Employees in AZ, CA, GA, MA, MD, MO, NC, NJ and TX must either live or work within the approved DMO® service area to be eligible to enroll in the DMO®.**

*Aetna Life Insurance Company underwrites Aetna Dental plans.*

| Control/Group number | Suffix | Account | Plan number |
|---|---|---|---|
| | | | |

**3. Aetna Vision℠ Preferred** ☐ Yes ☐ No

*Aetna Life Insurance Company underwrites Aetna Vision plans. First American Administrators, Inc. provides certain claims administration services. EyeMed Vision Care, LLC ("EyeMed") provides certain network administration services.*

## C. Individuals covered – *List individuals for whom you are enrolling or adding, changing or removing coverage. Add more sheets if needed.*

**NOTE FOR MEDICAL COVERAGE:** While the Affordable Care Act and state law mandate coverage of dependent children up to age 26, your plan may allow coverage beyond age 26. For instance, in Illinois, dependent coverage may be elected and can be extended up to age 30 if that dependent: 1) has served in the active or reserve component of the U.S. Armed Forces; 2) has received a release or discharge (other than a dishonorable discharge) from the military; 3) is unmarried; 4) is an Illinois resident; and 5) submits proof of military service using an Illinois Department of Veterans' Affairs Certificate of Release or Discharge from Active Duty form in order to enroll or remain enrolled past the age of 26. Please refer to your plan documents or contact your benefits administrator.

| 1 | ☐ Add ☐ Change ☐ Remove | **Employee name** (Last, first, middle initial) | | Sex (M/F) |
|---|---|---|---|---|
| Birthdate (MM/DD/YYYY) / / | Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally separated | Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision | Primary care physician (PCP) provider ID number | Current patient ☐ Yes |

| 2 | ☐ Add ☐ Change ☐ Remove | **Name** (Last, first, middle initial) ☐ **Spouse** ☐ **Civil union partner** ☐ **Domestic partner** | Sex (M/F) | Social Security number |
|---|---|---|---|---|
| Birthdate (MM/DD/YYYY) / / | Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision | | PCP provider ID number | Current patient ☐ Yes |

| 3 | ☐ Add ☐ Change ☐ Remove | **Name** (Last, first, middle initial) ☐ **Child** ☐ **Stepchild** ☐ **Other** ______ | Sex (M/F) | Social Security number |
|---|---|---|---|---|
| Birthdate (MM/DD/YYYY) / / | Status ☐ Different last name ☐ Incapacitated ☐ Military veteran | Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision | PCP provider ID number | Current patient ☐ Yes |

| 4 | ☐ Add ☐ Change ☐ Remove | **Name** (Last, first, middle initial) ☐ **Child** ☐ **Stepchild** ☐ **Other** ______ | Sex (M/F) | Social Security number |
|---|---|---|---|---|
| Birthdate (MM/DD/YYYY) / / | Status ☐ Different last name ☐ Incapacitated ☐ Military veteran | Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision | PCP provider ID number | Current patient ☐ Yes |

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## C. Individuals covered *(Continued)*

| 5 | ☐ Add<br>☐ Change<br>☐ Remove | **Name** (Last, first, middle initial) ☐ **Child** ☐ **Stepchild** ☐ **Other** ______________ | Sex (M/F) | Social Security number |
|---|---|---|---|---|

| Birthdate (MM/DD/YYYY) | Status | Choosing coverage for: | PCP provider ID number | Current patient |
|---|---|---|---|---|
| / / | ☐ Different last name<br>☐ Incapacitated<br>☐ Military veteran | ☐ Medical ☐ Dental<br>☐ Vision | | ☐ Yes |

| 6 | ☐ Add<br>☐ Change<br>☐ Remove | **Name** (Last, first, middle initial) ☐ **Child** ☐ **Stepchild** ☐ **Other** ______________ | Sex (M/F) | Social Security number |
|---|---|---|---|---|

| Birthdate (MM/DD/YYYY) | Status | Choosing coverage for: | PCP provider ID number | Current patient |
|---|---|---|---|---|
| / / | ☐ Different last name<br>☐ Incapacitated<br>☐ Military veteran | ☐ Medical ☐ Dental<br>☐ Vision | | ☐ Yes |

## D. Dependent information

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

| Name | Address |
|---|---|
| | |
| | |
| | |

## E. Coordination of benefits

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

If **yes**, will the Aetna coverage you're applying for replace the coverage you have now? ☐ Yes ☐ No

| Name of person | Carrier name | Name of person | Carrier name |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## F. Declining coverage – *Check all that apply.*

I understand I am eligible to apply for this coverage through my employer. However, I am declining the coverage I checked below:

| | | | |
|---|---|---|---|
| ☐ Employee: | ☐ Medical ☐ Dental<br>☐ Vision | **Reason for declining coverage**<br>☐ Parental group coverage<br>☐ Spouse / civil union partner / domestic partner group coverage<br>☐ Medicare<br>☐ Medicaid<br>☐ Retiree coverage<br>☐ COBRA / state continuation coverage | ☐ Insurance through another job<br>☐ TRICARE / Military coverage<br>☐ Individual coverage – On Exchange<br>☐ Individual coverage – Off Exchange<br>☐ Another group plan provided by my employer<br>☐ Do not want<br>☐ Other ______________ |
| ☐ Spouse / civil union partner / domestic partner: | ☐ Medical ☐ Dental<br>☐ Vision | | |
| ☐ Children: | ☐ Medical ☐ Dental<br>☐ Vision | | |

I certify I have the right to apply for this coverage. However, I am declining coverage as noted above. 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 and / or dependents.***<br>☐ I am declining coverage. **Employee signature:** X | ***Date (Month/Day/Year)*** |
|---|---|
| ***Please PRINT employee name:*** | |

## Conditions of enrollment

I understand that the following legal entities underwrite the insurance plans:

- Aetna Health Inc. and Aetna Health Insurance Company underwrite the Aetna QPOS plans.
- Aetna Life Insurance Company underwrites Aetna PPO plans, Aetna dental plans and Aetna Vision plans. First American Administrators, Inc. provides certain claims administration services. EyeMed Vision Care, LLC ("EyeMed") provides certain network administration services.

1. My employer's application determines coverage. I don't have coverage until Aetna approves my employee enrollment form and the employer application. Even if Aetna approves the employer application, any misstatements or omissions may result in denial of future claims. Aetna may rescind or reevaluate my coverage under the policy, as of the effective date, for eligibility and rating purposes. If Aetna voids or rescinds

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## Conditions of enrollment *(Continued)*

coverage, I may be entitled to a refund of any paid premiums from the effective date of coverage. Aetna will give at least 30 days advance written notice to any covered person affected by the proposed rescission. If I elect to receive electronic notifications, I will receive this notice in an electronic (email) format.

2. In order to underwrite the coverages listed on this enrollment form, Aetna may need information about medical history, services or treatment provided to anyone listed on this form. This may include information about mental health and substance use disorder. I authorize that the following entities can provide this information to Aetna or its agents:
   - Physicians
   - Other healthcare professionals
   - Hospitals
   - Other healthcare organizations ("providers"), including
     - Pharmacies
     - Pharmacy database benefit managers
3. I authorize Aetna to use and disclose such information to:
   - Affiliates
   - Providers
   - Other insurers
   - Third party administration
   - Vendors
   - Consultants
   - Governmental authorities with jurisdiction when necessary for:
     - Care or treatment
     - Payment for services
     - Operation of my health plan
     - Conduct related activities
4. I discussed the terms of this authorization with my competent adult dependents. They agreed to these terms. This authorization is valid for 30 months from the signature date. This authorization is valid for the term of the coverage for medical information collected in connection with a medical claim. This authorization is voluntary. But if I don't sign this form, my ability to enroll in the plan may be affected. I have the right to revoke this authorization in writing to Aetna at any time. I can't revoke authorization for information already used or disclosed before I revoked my authorization. I am entitled to receive a copy of this authorization upon request. A photocopy is as valid as the original.
   - The Group Agreement / Group Policy determines the rights and responsibilities of members and will govern in the event they conflict with any:
     - Benefits comparison
     - Summary
     - Other description of the plan
   - Participating physicians, hospitals and other health care providers are independent contractors. They are not Aetna agents or employees. We cannot guarantee the availability of any particular provider. Any provider network is subject to change. We will provide a notice of the change in accordance with applicable state law.
5. I understand that, with certain exceptions described in the plan documents, HMO and DMO© plans only provide coverage for covered benefits. The plan documents also describe if I need a referral for certain procedures, and who can provide care. Covered services must be performed by:
   - Participating primary care physicians
   - Participating primary care dentists
   - Participating specialists
   - Participating hospitals
   - Participating pharmacies
   - Participating dentists
   - Other participating providers as authorized by a referral from a participating primary care physician
6. I authorize the substitution of generic pharmaceuticals for the brand-name products, as provided by law, for prescriptions filled under any pharmacy benefit.

I represent that all information supplied in this form is true and complete. I have read and agree to the conditions of enrollment and intentional misrepresentation on this Employee Enrollment / Change Form.
I understand that in the event I fail to sign this form within 31 days or Aetna does not receive the request within a reasonable time, my eligibility may be affected.
I am employed by the employer shown on page 1. I am working full time or at least 25 hours or more a week for this employer at the regular place of business. I authorize deductions from my earnings for any contributions required for coverage. I agree to make any necessary payments required for coverage.
**Intentional misrepresentation**: Any person who knowingly and with intent to defraud any insurance company or other person files an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact materials thereto commits a fraudulent insurance act.

**To receive documents online, please visit your secure member account at aetna.com.**

| ***Please sign here ONLY if you are enrolling in coverage for yourself and / or dependents.*** ***Employee signature (required)*** **X** | ***Employee email*** | ***Date (Month/Day/Year)*** |
| --- | --- | --- |