

NOTE: Before you return this form to your employer, you may wish to tape or staple the form so that health information is not visible. This will help keep your health information private.



Texas Employee Enrollment/Change Form

Aetna VisionSM Preferred plans, Aetna PPO plans, Aetna OAMC plans, Aetna OAEPO plans, Aetna Whole Health OAEPO plans and Aetna Indemnity plans are underwritten by Aetna Life Insurance Company. Aetna HMO plans are underwritten by Aetna Health Inc. Aetna Dental plans are provided or administered by Aetna Dental Inc. and 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 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.

Group number
Aetna member ID number (if available)

Company name			
Effective date	<input type="checkbox"/> New hire <input type="checkbox"/> Rehire / reinstatement* <input type="checkbox"/> New group enrollment <input type="checkbox"/> Late enrollment <input type="checkbox"/> Waiver <input type="checkbox"/> Open enrollment <input type="checkbox"/> Loss of coverage	<input type="checkbox"/> Add spouse <input type="checkbox"/> Add domestic partner <input type="checkbox"/> Add dependent child <input type="checkbox"/> Change of coverage <input type="checkbox"/> Name change	<input type="checkbox"/> Employee termination date _____ <input type="checkbox"/> Remove spouse <input type="checkbox"/> Remove domestic partner <input type="checkbox"/> Remove dependent child <input type="checkbox"/> Cancel coverage <input type="checkbox"/> Other _____
Date of hire			
* Employees rehired within 1 year do not need to meet the waiting period and should be enrolled as soon as they are rehired. Does not apply to Supplemental or Dependent Life Insurance.			
<input type="checkbox"/> COBRA <input type="checkbox"/> State continuation for: <input type="checkbox"/> Employee <input type="checkbox"/> Dependent Length of continuation: <input type="checkbox"/> 18 months <input type="checkbox"/> 36 months <input type="checkbox"/> 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 dependents, including spouse or domestic partner, enrolling for medical coverage	
Salary \$ _____	<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	Number of hours worked a week	Check one: <input type="checkbox"/> Full time <input type="checkbox"/> 1099 <input type="checkbox"/> Seasonal <input type="checkbox"/> COBRA <input type="checkbox"/> State Continuation <input type="checkbox"/> Part time <input type="checkbox"/> Retiree <input type="checkbox"/> Temporary <input type="checkbox"/> Union	
Subscriber primary language (other than English) Primer Idioma del suscriptor (que no sea el Ingles) What is your primary Language? ¿Cuál es su primer idioma? _____			Subscriber disability Do you have a disability which affects your ability to communicate or read? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , please indicate the nature of your disability. _____	

B. Coverage selection (Top boxes for employer and Aetna use only)

Control/Group number	Suffix	Account	Plan number	Class Code
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1. Medical ☐ Yes ☐ No *Check one:*
☐ Aetna OAMC Plan _____
☐ Aetna OAMC 1000 80/50 IVF Plan _____
☐ Aetna Whole Health OAEPO Plan _____
☐ Aetna AWH OAEPO 1000 80 IVF Plan _____
☐ Aetna OAEPO Plan _____
☐ Aetna OAEPO 1000 80 IVF Plan _____
☐ Aetna Kelsey Care HMO Plan _____
☐ Aetna Kelsey Care HMO 0 Ded 50% IVF Plan _____
☐ Aetna PPO Plan _____
☐ Aetna PPO 2000 80/50 IVF Plan _____
☐ Aetna Indemnity Plan _____
☐ Aetna Indemnity 2000 80% IVF Plan _____

Control/Group number	Suffix	Account	Plan number
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2. Dental ☐ Yes ☐ No *To enroll, enter the plan number and name below.*
Non-voluntary plans – Plan number _____ Plan name _____
 FOC Options: ☐ DMO® or ☐ PDN
Voluntary plans – Plan number _____ Plan name _____
 FOC Options: ☐ DMO® or ☐ PDN

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 number	Suffix	Account	Plan number
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3. Vision ☐ Yes ☐ No
 Aetna VisionSM Preferred

C. Individuals covered – List individuals for whom you are enrolling or adding, changing or removing coverage. Add more sheets if needed.**NOTE: Enter Domestic partner ONLY if your employer has elected that coverage.**

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.

You can select an Ob / Gyn but are not required to do so. Instead, you may receive obstetrical and gynecological services from your primary care physician.

1	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Employee name (Last, first, middle initial)	Sex (M/F)
Birthdate (MM/DD/YYYY) / /		Incapacitated N/A	Choosing coverage for: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Primary office ID number (if applicable) HMO only	Current patient Yes <input type="checkbox"/>	Ob / Gyn office ID number (if applicable)	Current patient Yes <input type="checkbox"/>
		Dental office ID number (if applicable) DMO only	Current patient Yes <input type="checkbox"/>

Continued on next page

C. Individuals covered (Continued)

2	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner	Name (Last, first, middle initial)		Sex (M/F)	Social Security number
	Birthdate (MM/DD/YYYY) / /		Incapacitated N/A	Choosing coverage for: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		
Primary office ID number (if applicable) HMO only		Current patient Yes <input type="checkbox"/>	Ob / Gyn office ID number (if applicable)		Current patient Yes <input type="checkbox"/>	Dental office ID number (if applicable) DMO only Current patient Yes <input type="checkbox"/>

3	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	Name (Last, first, middle initial)		Sex (M/F)	Social Security number
	Birthdate (MM/DD/YYYY) / /		Incapacitated Yes <input type="checkbox"/>	Choosing coverage for: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		
Primary office ID number (if applicable) HMO only		Current patient Yes <input type="checkbox"/>	Dental office ID number (if applicable) DMO only		Current patient Yes <input type="checkbox"/>	

4	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	Name (Last, first, middle initial)		Sex (M/F)	Social Security number
	Birthdate (MM/DD/YYYY) / /		Incapacitated Yes <input type="checkbox"/>	Choosing coverage for: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		
Primary office ID number (if applicable) HMO only		Current patient Yes <input type="checkbox"/>	Dental office ID number (if applicable) DMO only		Current patient Yes <input type="checkbox"/>	

5	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	Name (Last, first, middle initial)		Sex (M/F)	Social Security number
	Birthdate (MM/DD/YYYY) / /		Incapacitated Yes <input type="checkbox"/>	Choosing coverage for: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		
Primary office ID number (if applicable) HMO only		Current patient Yes <input type="checkbox"/>	Dental office ID number (if applicable) DMO only		Current patient Yes <input type="checkbox"/>	

6	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	Name (Last, first, middle initial)		Sex (M/F)	Social Security number
	Birthdate (MM/DD/YYYY) / /		Incapacitated Yes <input type="checkbox"/>	Choosing coverage for: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		
Primary office ID number (if applicable) HMO only		Current patient Yes <input type="checkbox"/>	Dental office ID number (if applicable) DMO only		Current patient Yes <input type="checkbox"/>	

D. Dependent information

List any dependent in Section C with a different last name or living at another address.	
Name	Address

E. Coordination of benefits

Will you have other health insurance at the same time as this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes , will the Aetna coverage you're applying for replace the coverage you have now? <input type="checkbox"/> Yes <input type="checkbox"/> 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:			
<input type="checkbox"/> Employee: <div> <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision </div>	Reason for declining coverage <div> <input type="checkbox"/> Parental group coverage <input type="checkbox"/> Insurance through another job <input type="checkbox"/> Spouse / domestic partner group coverage <input type="checkbox"/> TRICARE / Military coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Individual coverage – On Exchange <input type="checkbox"/> Medicaid <input type="checkbox"/> Individual coverage – Off Exchange <input type="checkbox"/> Retiree coverage <input type="checkbox"/> Another group plan provided by my employer <input type="checkbox"/> COBRA coverage <input type="checkbox"/> Do not want <input type="checkbox"/> State continuation coverage <input type="checkbox"/> Other _____ </div>		
<input type="checkbox"/> Spouse / domestic partner: <div> <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision </div>			
<input type="checkbox"/> Child(ren): <div> <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision </div>			
I certify I have been given 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 dependent(s).			Date (Month/Day/Year)
<input type="checkbox"/> I am declining coverage. Employee signature: X			
Please PRINT employee name:			

G. Medicare information

Name of person	Medicare Part A	Medicare Part B	Medicare Part D	Over age 65	Disability	End-stage renal disease effective 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	

Conditions of enrollment

<p>On behalf of myself and the dependents listed, I agree to or with the following:</p> <ol style="list-style-type: none"> I acknowledge that by enrolling in the following plans, coverage is provided by the following entities (collectively referred to as "Aetna"): <ul style="list-style-type: none"> Aetna HMO plans: Aetna Health Inc. Aetna Dental DMO: Aetna Dental Inc. Aetna VisionSM Preferred plans: Aetna Life Insurance Company; certain claims adjudication and other administrative services are provided by First American Administrators, Inc. (an affiliate of EyeMed Vision Care, LLC) and / or its affiliates Aetna Dental and other health coverages: Aetna Life Insurance Company. I understand and agree that my employer's application will determine coverage and that there is no coverage until Aetna has approved both my employee enrollment form and the employer applications. Even if this enrollment form is approved, any misstatements or omissions may result in future claims being denied. I understand and agree that this Enrollment / Change 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"), to give to Aetna or its agent information concerning the medical history, services or treatment provided to anyone listed on this Enrollment / Change 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 / domestic partner 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 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. 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.
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Conditions of enrollment (Continued)

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® and Aetna Specialty Pharmacy®, all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, and Aetna Specialty Pharmacy, LLC, are subsidiaries 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 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 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.

Misrepresentation

7. Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any intentional misrepresentation of material fact or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

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 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 eligibility and my dependents' eligibility may be affected.

I am employed by the employer shown on page 1 at the regular place of business and I am working full time, usually 25 hours a week. I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments required for coverage.

If you have questions concerning the benefits and services that are provided by or excluded under this Agreement, please contact a Member Services representative at 1-800-323-9930 before signing this form.

**If you wish to receive documents online, please visit your secure member account at
aetna.com/individuals-families/aetna-navigator.html**

***Please sign here ONLY if you are enrolling in coverage for yourself
and / or dependent(s).***

Employee signature (required)

Employee email

Date (Month/Day/Year)

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