aetna®

Delaware (1 – 100 Eligible Employees)
Employee Enrollment/Change Form

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 Section B. Please use only black ink to complete this form.**

Group Number
Member Aetna ID Number (if available)

Company Name			
Effective Date **Date of Hire** **Benefit Waiting Period*** ☐ Class 1 ☐ Class 2 *only required when your employer has 2 benefit waiting periods	☐ New Hire ☐ Rehire/Reinstatement* ☐ New Group Enrollment ☐ Late Enrollment ☐ Waiver ☐ Open Enrollment ☐ Loss of Coverage *Does not apply to Supplemental or Dependent Life insurance	☐ Add Spouse ☐ Add Domestic Partner ☐ Add Civil Union Partner ☐ Add Dependent Child ☐ Change of Coverage ☐ Name Change	☐ Employee Termination ☐ Remove Spouse ☐ Remove Domestic Partner ☐ Remove Civil Union Partner ☐ Remove Dependent Child ☐ Cancel Coverage ☐ Other _____

☐ **COBRA** ☐ **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 - ***Must be completed by the employee.***

Last Name, First Name, M.I.		Social Security Number	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated
Home Address	Apt. No.	City, State	ZIP Code
Work Address		City, State	ZIP Code
Home Telephone ( ) -	Work Telephone ( ) -	Job Title	Primary Language Spoken *(Optional)*
Salary (if electing Life coverage) $ _____	☐ Hourly ☐ Weekly ☐ Monthly	No. of Hours Worked Per Week	Check One ☐ Full-Time ☐ 1099 ☐ Seasonal ☐ COBRA ☐ Part-Time ☐ Retiree ☐ Temporary ☐ Union

B. 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/AD&D Ultra® ☐ Vision ☐ STD ☐ LTD ☐ Life & Disability Packaged Plan	**Reason for declining coverage** ☐ Spouse/Civil Union/Domestic Partner group coverage ☐ Parental group coverage ☐ COBRA coverage ☐ Medicare ☐ Medicaid ☐ Retiree coverage ☐ Another group plan provided by my employer
☐ Spouse/ Civil Union/ Domestic Partner	☐ Medical ☐ Dental ☐ Life/AD&D Ultra® ☐ Vision	☐ Insurance through another job ☐ TRICARE ☐ VA coverage ☐ Individual coverage - On Exchange ☐ Individual coverage - Off Exchange ☐ I have no other coverage ☐ I do not want ☐ Other _____
☐ Child(ren):	☐ Medical ☐ Dental ☐ Life/AD&D Ultra® ☐ Vision	

I certify 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 and/or your dependent(s).	***Date (Month/Day/Year)***
☐ I AM DECLINING COVERAGE: **Employee Signature X**	
Please PRINT employee name:	

C. Coverage Selection ***(Shaded sections for Employer/Aetna Use Only)***

Control/Group No.	Suffix	Account	Plan No.	Class Code

1. Medical ☐ Yes ☐ No *To enroll, check one in each category: Metal, Network, Product Type, and HSA. Then write in the plan option elected.*

Choose 1 — **Metal**: ☐ Platinum ☐ Gold ☐ Silver ☐ Bronze

Choose 1 — **Product Type**: ☐ HNOption ☐ PPO ☐ Indemnity

Choose 1 — **HSA:** ☐ Yes ☐ No

Plan Option: _____

Control/Group No.	Suffix	Account	Plan No.

2. Dental ☐ Yes ☐ No **(Not available to groups of one.)**

To enroll, enter plan number and name elected below.

Standard Plans: Plan Number: _____ Plan Name: _____

Voluntary Plans: Plan Number: _____ Plan Name: _____

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. Vision (if applicable)

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

Control/Group No.	Suffix	Account	Plan No.

4. Life and Disability ☐ Yes ☐ No

Life/AD&D Ultra® (for groups with 2-9 employees) *Check applicable boxes.*

☐ **Employee** Basic Life/AD&D Ultra®

Life/AD&D Ultra® (for groups with 10-100 employees) *Check applicable boxes.*

☐ **Employee** ☐ Basic Life/AD&D Ultra® ☐ Supplemental Life/AD&D Ultra®

☐ **Spouse** ☐ Optional Spouse Life/AD&D Ultra®

☐ **Child** ☐ Optional Child Life/AD&D Ultra®

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

The Group Policy grants the member the authority to designate a beneficiary. 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(ies) predeceases the insured or is otherwise barred by a state law and/or a legally binding document addressing benefit payments. The employee is automatically the primary beneficiary for dependent life and accidental death and personal loss coverage (AD&D Ultra®) 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/AD&D Ultra® Primary							
Basic Life/AD&D Ultra® Contingent							
Supplemental Life/AD&D Ultra® Primary							
Supplemental Life/AD&D Ultra® Contingent							

C. Coverage Selection *(Continued)*

SPOUSAL CONSENT FOR COMMUNITY PROPERTY STATES ONLY – 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 (*Coverage for **Employee** only)* *Check applicable boxes.*

Short Term Disability (for groups with 2-100 employees)	☐ Yes	☐ No
Long Term Disability (for groups with 10-100 employees)	☐ Yes	☐ No
Life and Disability Packaged Plan (for groups with 2-50 employees)	☐ Yes	☐ No

D. 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	(**A**)dd (**C**)hange ___ (**R**)emove	**Employee Name** (Last, First, M.I.)				Sex (M/F)	Birthdate (MM/DD/YYYY) / /		
Coverage Election ☐ Medical ☐ Dental ☐ Vision ☐ Life/AD&D Ultra® ☐ STD ☐ LTD ☐ Life & Disability Packaged Plan			If choosing HMO, Primary Office ID #		Current Patient **Yes** ☐	If choosing DMO, Primary Office ID #		Current Patient **Yes** ☐	
2	(**A**)dd (**C**)hange ___ (**R**)emove	**Name** (Last, First, M.I.) ☐ **Spouse** ☐ **Domestic Partner** ☐ **Civil Union**			Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /		
Coverage Election ☐ Medical ☐ Dental ☐ Vision ☐ Life/AD&D Ultra®			If choosing HMO, Primary Office ID #		Current Patient **Yes** ☐	If choosing DMO, Primary Office ID #		Current Patient **Yes** ☐	
3	(**A**)dd (**C**)hange ___ (**R**)emove	**Name** (Last, First, M.I.) ☐ **Child** ☐ **Stepchild** ☐ **Other**			Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /		
Coverage Election ☐ Medical ☐ Dental ☐ Vision ☐ Life/AD&D Ultra®		Incapacitated ☐ Yes ☐ No	If choosing HMO, Primary Office ID #		Current Patient **Yes** ☐	If choosing DMO, Primary Office ID #		Current Patient **Yes** ☐	
4	(**A**)dd (**C**)hange ___ (**R**)emove	**Name** (Last, First, M.I.) ☐ **Child** ☐ **Stepchild** ☐ **Other**			Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /		
Coverage Election ☐ Medical ☐ Dental ☐ Vision ☐ Life/AD&D Ultra®		Incapacitated ☐ Yes ☐ No	If choosing HMO, Primary Office ID #		Current Patient **Yes** ☐	If choosing DMO, Primary Office ID #		Current Patient **Yes** ☐	
5	(**A**)dd (**C**)hange ___ (**R**)emove	**Name** (Last, First, M.I.) ☐ **Child** ☐ **Stepchild** ☐ **Other**			Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /		
Coverage Election ☐ Medical ☐ Dental ☐ Vision ☐ Life/AD&D Ultra®		Incapacitated ☐ Yes ☐ No	If choosing HMO, Primary Office ID #		Current Patient **Yes** ☐	If choosing DMO, Primary Office ID #		Current Patient **Yes** ☐	
6	(**A**)dd (**C**)hange ___ (**R**)emove	**Name** (Last, First, M.I.) ☐ **Child** ☐ **Stepchild** ☐ **Other**			Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /		
Coverage Election ☐ Medical ☐ Dental ☐ Vision ☐ Life/AD&D Ultra®		Incapacitated ☐ Yes ☐ No	If choosing HMO, Primary Office ID #		Current Patient **Yes** ☐	If choosing DMO, Primary Office ID #		Current Patient **Yes** ☐	

E. Dependent Information

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

Name	Address

F. Coordination of Benefits

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

If Yes, will Aetna coverage being applied for replace your current in-force 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 the following plans, coverage is provided by the following entities (collectively referred to as "Aetna"):
   - Aetna Health Network Option plans: Aetna Health Inc. and Aetna Health Insurance Company.
   - Aetna PPO plans: Aetna Life Insurance Company.
   - Aetna Vision: 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.
   - Life, Accidental Death & Personal Loss Coverage, disability, dental and all other 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 the employer application have been accepted and approved by Aetna. Even if this enrollment form is approved, any intentional and material misstatements or omissions that amount to fraud, or which would have affected the carrier's rating, offering or issuing of coverage impacted, may result in future claims being denied and the policy or my coverage under the policy being rescinded or reevaluated, as of the effective date, for eligibility and rating purposes. Failure to disclose all health information encompassed by the questionnaire will be deemed to be material omissions for rating purposes.

   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 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, dependent children are eligible from birth up to their 26th birthday.

   For disability coverage: I understand that the effective date of my insurance 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.
3. 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"), including pharmacies and 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 Form, including those involving mental health, substance abuse and HIV/AIDS. 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/civil union 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 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 plans described above.
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 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 deceive or 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 material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I represent that all information supplied in this form is true and complete to the best of my knowledge and belief. I have read and agree to the Conditions of Enrollment and Misrepresentation on this Delaware 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**, and I am working full time at least 30 hours per week (or 25 hours per week if my employer extends coverage) 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.

Please sign here ONLY if you are enrolling in coverage for yourself and/or dependent(s). ***Employee Signature*** *(Required to enroll)* **X**	***Employee E-mail Address***	***Date (Month/Day/Year)*** *Required*

Additional Conditions and Instructions for Designation of Beneficiary

Conditions for Designation of Beneficiary

- **Please note:** The Group Policy grants only the member the authority to designate a beneficiary. If you do not name a beneficiary, payment will be made to your survivors as described in the Group Policy's Beneficiary provision. You should execute the Designation of Beneficiary section of this form to ensure payment is made to the person you want.
- Unless otherwise expressly provided in the Designation of Beneficiary section of this form, if any named primary beneficiary predeceases you, the life proceeds shall be paid equally to the remaining named primary beneficiary or beneficiaries. All primary beneficiaries must predecease you before the life proceeds will be paid to any contingent beneficiaries.
- If this Designation of Beneficiary provides for payment to a trustee under a trust agreement, Aetna Life Insurance Company (Aetna) shall not be obliged to know or be liable for the terms and conditions of the trust agreement. If your beneficiary is a minor at the time of your death, Aetna may require the court to appoint a guardian to receive the life proceeds for the minor.
- Aetna will be fully discharged of its duties as to the extent of the payment made. Aetna is not responsible for how the payment is used.
- 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.

- 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.