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 the health information pages are not visible.

aetna®

Virginia Employee Enrollment/Change Form
(1 - 50 Eligible Employees)
Aetna Life Insurance Company, Aetna Health Inc.

Life, Accidental Death & Personal Loss (AD&PL), Disability, Preferred Provider Organization (PPO), PPO Health Savings Account (HSA) Compatible and Indemnity plans are underwritten by Aetna Life Insurance Company. Health Maintenance Organization (HMO), Health Network Only and Health Network Only HSA Compatible plans are underwritten by Aetna Health Inc. The Dental Maintenance Organization (DMO) and Dental Preferred Provider Organization (PPO) plans are underwritten by Aetna Life Insurance Company. "Aetna" is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies.

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 A and B.

Member Aetna ID Number (if available)

Company Name				
Effective Date Date of Hire	☐ New Hire ☐ Rehire/Reinstatement ☐ New Group Enrollment ☐ Late Enrollment ☐ Waiver ☐ Open Enrollment ☐ Other _____	☐ Change of Coverage ☐ Add Spouse/Domestic Partner ☐ Add child ☐ Name Change ☐ Other _____	☐ Employee Termination ☐ Remove Spouse/ Domestic Partner ☐ Remove Child ☐ Cancel Coverage	☐ COBRA ☐ State Continuation for: ☐ Employee ☐ Dependent Length of Continuation: ☐ 18 ☐ 36 ☐ Other ____ Original Qualifying Event Date _____ Qualifying Event _____

A. Employee Information – *Must be completed by the employee.*

Social Security Number	Last Name, First Name, M.I.		Job Title	
Home Address (PO Box not acceptable)		Apt. No.	City, State	ZIP Code
Work Address (PO Box not acceptable)			City, State	ZIP Code
Home Telephone ( ) -	Work Telephone ( ) -		Primary Language Spoken (Optional)	Number of Dependents including Spouse/ Domestic Partner enrolling for coverage
No. of Hours Worked Per Week	Check One ☐ Full-Time ☐ Part-Time ☐ 1099 ☐ Retiree ☐ Seasonal ☐ Temporary ☐ COBRA ☐ Union			

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

☐ Medical Coverage declined for: ☐ Myself ☐ Children ☐ Spouse/Domestic Partner ☐ Dental Coverage declined for: ☐ Myself ☐ Children ☐ Spouse/Domestic Partner	Reason for declining coverage: ☐ Spouse/Domestic Partner group coverage ☐ Parental group coverage ☐ Medicare ☐ Medicaid ☐ Retiree coverage ☐ Another group plan provided by my employer ☐ COBRA coverage ☐ Insurance through another job ☐ TRICARE Military coverage ☐ Individual coverage – On or Off Exchange ☐ 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.

Employee Signature if declining coverage for employee/dependent(s) - Required Employee Signature X	*Date (Month/Day/Year)*

C. 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

- ☐ VA HMO – Plan Option: _____
- ☐ VA Health Network Only – Plan Option: _____
- ☐ VA Health Network Only – HSA Compatible – Plan Option: _____
- ☐ VA PPO – Plan Option: _____
- ☐ VA PPO HSA Compatible – Plan Option: _____
- ☐ VA Indemnity – Plan Option: _____

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

2. Dental – *To enroll, enter plan number and name elected below.*

Contributory Plan:
Plan Number: _____
Plan Name: _____
If Freedom-of-Choice, check: ☐ DMO® *or* ☐ PPO

Voluntary Plan:
Plan Number: _____
Plan Name: _____
If Freedom-of-Choice, check: ☐ DMO® *or* ☐ PPO

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

Control/Group No.	Suffix	Account	Plan No.

3. Life and Disability – *Check applicable boxes.*

☐ Basic Life/AD&D Ultra® ☐ Optional Dependent Life ☐ Life & Disability Packaged Plan

Full Beneficiary Name (First, Middle, Last)	Beneficiary Social Security Number	Birthdate (MM/DD/YYYY) / /

Beneficiary Address (Number, Street, Apt. No., City, State, ZIP Code)	Telephone Number ( ) -	Relationship to Employee

D. Individuals 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 children up to age 26, your plan may allow coverage to age 26 and beyond for medical plans and some dental plans. Some exceptions apply. Please refer to your plan documents or contact your benefits administrator.

If any person has used tobacco products (cigarettes, pipe, cigars, snuff, or chewing tobacco) an average of four or more times per week within the past six months, ✓ check below. Religious or ceremonial uses of tobacco (for example, by American Indians and Alaska Natives) are exempt. This only applies to enrolling person(s) that meet or exceed the state-defined legal tobacco age.

1	(A)dd (C)hange ___ (R)emove	Employee Name (Last, First, M.I.)	Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /

Coverage Election ☐ Medical ☐ Dental ☐ Life/Disability	If choosing HMO, Primary Office ID #	Current Patient Yes ☐	If choosing DMO, Primary Office ID #	Current Patient Yes ☐

Tobacco Use ☐ Yes ☐ No	Currently participating in Quit Smoking Program ☐ Yes ☐ No	Incapacitated ☐ Yes ☐ No

2	(A)dd (C)hange ___ (R)emove	Name (Last, First, M.I.) ☐ Spouse ☐ Domestic Partner	Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /

Coverage Election ☐ Medical ☐ Dental ☐ Life	If choosing HMO, Primary Office ID #	Current Patient Yes ☐	If choosing DMO, Primary Office ID #	Current Patient Yes ☐

Tobacco Use ☐ Yes ☐ No	Currently participating in Quit Smoking Program ☐ Yes ☐ No	Incapacitated ☐ Yes ☐ No

continued on next page

D. Individuals Covered *(Continued)*

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 ☐ Life		If choosing HMO, Primary Office ID #	Current Patient Yes ☐	If choosing DMO, Primary Office ID #	Current Patient Yes ☐
Tobacco Use ☐ Yes ☐ No		Currently participating in Quit Smoking Program ☐ Yes ☐ No		Incapacitated ☐ Yes ☐ No	

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 ☐ Life		If choosing HMO, Primary Office ID #	Current Patient Yes ☐	If choosing DMO, Primary Office ID #	Current Patient Yes ☐
Tobacco Use ☐ Yes ☐ No		Currently participating in Quit Smoking Program ☐ Yes ☐ No		Incapacitated ☐ Yes ☐ No	

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 ☐ Life		If choosing HMO, Primary Office ID #	Current Patient Yes ☐	If choosing DMO, Primary Office ID #	Current Patient Yes ☐
Tobacco Use ☐ Yes ☐ No		Currently participating in Quit Smoking Program ☐ Yes ☐ No		Incapacitated ☐ Yes ☐ No	

E. Dependent Information

List any dependent in Section D living at another address.

Name	Address

For Dependent Life: If applying for dependent life coverage and the dependent is age 19 and over and a full-time student, provide the following:

Child Name	School Name	Expected Graduation Date	Number of Credit Hours

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

G. Case Management (OPTIONAL – This information will be used to help coordinate your care. It will not impact your premium rate or eligibility for coverage. Case management is a process of identifying individuals with certain medical conditions associated with complex health care needs and helps us better provide you with any care you may need.)

- ☐ AIDS
- ☐ ALS (Amyotrophic lateral sclerosis) - Lou Gehrig's disease
- ☐ Auto Immune Disorders (e.g., scleroderma, Systemic Lupus)
- ☐ Traumatic Brain Injury
- ☐ Cerebral Palsy using wheelchair
- ☐ Chronic Pain
- ☐ Congestive Heart Failure
- ☐ COPD using oxygen
- ☐ Cor Pulmonale
- ☐ Defibrillator /AICD/ Implantable Cardioverter
- ☐ End of Life/Hospice
- ☐ Hypertensive Heart Disease
- ☐ Hypertensive Renal Disease
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Myasthenia Gravis
- ☐ Paralysis
- ☐ Paraplegic
- ☐ Pregnant - high risk or multiple births
- ☐ Quadriplegic

Name of Individual	Condition(s)

Conditions of Enrollment

On behalf of myself and the dependents listed in Section D on Pages 2 and 3, 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"):
   - HMO and Health Network Only Plans: Aetna Health Inc.
   - PPO and Indemnity Plans: Aetna Life Insurance Company
   - Dental Plans: Aetna Life Insurance Company
   - Life, Accidental Death & Personal Loss (AD&PL), disability 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 application have been accepted and approved by Aetna. Even if this application is approved, any misstatements or omissions 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.
   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 19th birthday, or up to their 23rd birthday, if a full-time student.
3. I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("Providers"), including pharmacies and/or pharmacy database benefit managers, to give to the Aetna company(ies) underwriting coverage(s) for the product(s) checked in the Coverage Selection section on Page 2, or its (their) agent(s), information concerning the medical history, services or treatment provided to anyone listed on this Application, including those involving mental health, substance use disorder 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. This authorization is applicable to the Aetna company(ies) underwriting coverage(s) for the product(s) checked in Section C on Page 2. I have discussed the terms of this authorization with my spouse or domestic partner and competent adult dependents, and I have obtained their consent to those terms. This authorization will remain valid for 30 months from the date I signed it or in the case of the information described above being collected in connection with a medical claim, this authorization will be valid for the term of the coverage. In the case of a life claim, the authorization will remain valid for the duration of the claim. I understand that I or my authorized representative is 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 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.

Authorization

7. I authorize deductions from my earnings for any contributions required for coverage, and I agree to make any necessary payments as required for coverage.
8. I authorize the substitution of generic pharmaceuticals for the brand-name products, as provided by law, for prescriptions filled under any pharmacy benefit.

Misrepresentation

9. 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 materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent 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. I have read and agree to the Conditions of Enrollment, Authorizations 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 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 for this employer at the regular place of business.

The undersigned subscriber, and agent, when an agent is involved in the enrollment of Basic Life Benefits Greater than the Guaranteed Issue Level, certify that the subscriber has read, or had read to him/her the completed enrollment form and that the subscriber realizes that any false statement or misrepresentation in the enrollment form may result in loss of coverage under the policy.

Employee Signature **X**	***Date (Month/Day/Year)***
Employee E-mail Address (optional)	*In enrolling in an HMO/Health Network Only or DMO plan, I acknowledge that a PPO or dental PPO plan has been offered to me.* ☐ Yes ☐ No
Insurance Agent Signature **X**	***Date (Month/Day/Year)***