# Ohio Small Group Business (2 - 50 Eligible Employees) Employee Enrollment/Change Form

Aetna®

Member Aetna ID Number (if available)

Employer Name

**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 G.**

**Effective Date**

**Date of Hire**

☐ New Hire ☐ Late Enrollment
☐ Rehire/Reinstatement ☐ Other _____
☐ New Group Enrollment

☐ Change of Coverage
☐ Add Spouse/Dependent Child
☐ Name Change ☐ Other _____

☐ Employee Termination
☐ Remove Spouse/Dependent Child
☐ Cancel Coverage

COBRA/State Continuation for:
☐ Employee ☐ Dependent
Length of Continuation:
☐ 18 ☐ 36 ☐ Other _____
Original Qualifying Event Date _____
Reason _____

## 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 |
|---|---|---|---|---|
| | | | | |

| Control/Group No. | Suffix | Account | Plan No. |
|---|---|---|---|
| | | | |

| Control/Group No. | Suffix | Account | Plan No. |
|---|---|---|---|
| | | | |

**1. Medical** - Check one.

☐ Choice® POS (Open Access) - Plan Option _____
☐ Managed Choice® POS (Open Access) - Plan Option _____
☐ Open Choice® PPO - Plan Option _____
☐ Indemnity
☐ Other _____

**2. Dental** - Check one.

**Standard Plans:**

☐ Option 1: DMO
☐ Option 2: Freedom-of-Choice PPO Max ☐ DMO ☐ PPO
☐ Option 3: PPO Max
☐ Option 4: Freedom-of-Choice PPO ☐ DMO ☐ PPO
☐ Option 5: Active PPO
☐ Option 6: PPO 1500
☐ Out-of-State PPO

**Voluntary Plans:**

☐ Option V1: DMO
☐ Option V2: Freedom-of-Choice ☐ DMO ☐ PPO
☐ Option V3: PPO Max
☐ Out -of-State PPO

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

**3. Life and Disability**

☐ Basic Life/AD&D Ultra™
☐ Optional Dependent Life
☐ Short Term Disability
☐ Life & Disability Packaged Plan

Beneficiary Designation - **Full Name** (First, Middle, Last)

Beneficiary Social Security No. | Relationship to Employee

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

| Social Security Number | Last Name, First Name, M.I. | Job Title | Home Telephone | Primary Language Spoken (Optional) |
|---|---|---|---|---|
| | | | | |

| Home Address | Apt. No. | City, State | ZIP Code |
|---|---|---|---|
| | | | |

| Work Address | City, State | ZIP Code | Work Telephone |
|---|---|---|---|
| | | | |

**Salary (required)** $ ☐ Hourly ☐ Weekly ☐ Monthly

No. of Hours Worked Per Week

Check One ☐ Full-time ☐ Part-time ☐ 1099 ☐ Retired ☐ Seasonal ☐ Temporary

No. of Dependents Including Spouse

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

| Name (Last, First, M.I.) | Sex M/F | Social Security Number | Birthdate MM / DD / YYYY | Relationship | Height (ft, in) | Weight (lbs) | Status | Coverage Election | PCP Provider ID# |
|---|---|---|---|---|---|---|---|---|---|
| Employee 1. | | | | | | | ☐ Single ☐ Divorced ☐ Married ☐ Widowed ☐ Legally Separated | ☐ Medical ☐ Dental ☐ Life/Dis | |
| 2. | | | | ☐ Spouse ☐ Other | | | ☐ Different last name | ☐ Medical ☐ Dental ☐ Life | |
| Child 3. | | | | ☐ Child ☐ Stepchild ☐ Other | | | ☐ Different last name ☐ Lives at another address ☐ Full-time Student (+19) ☐ Disabled (+19) | ☐ Medical ☐ Dental ☐ Life | |
| Child 4. | | | | ☐ Child ☐ Stepchild ☐ Other | | | ☐ Different last name ☐ Lives at another address ☐ Full-time Student (+19) ☐ Disabled (+19) | ☐ Medical ☐ Dental ☐ Life | |

## D. Dependent Information

List any dependent in Section C living at another address. Name _____
Why? What is their address?

If any dependent's last name differs from yours, explain. Name _____
Reason

If age 19+ and a full-time student, provide the following:

| Child Name | School Name | Expected Graduation Date | Number of Credit Hours |
|---|---|---|---|
| | | | |
| | | | |

## E. Medicare Information

| Name of Person | Medicare Part A | Medicare Part B | Medicare Part D | Over Age 65 | Disability | End-Stage Renal Disease Eff Date |
|---|---|---|---|---|---|---|
| | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | |
| | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | |

*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 that pages 2 and 3 are not visible.*

## F. Other Insurance

Does anyone enrolling on this enrollment form have current or prior coverage? ☐ Yes ☐ No

Proof of coverage must accompany this enrollment form for pre-existing condition credit and if an employee is waiving coverage. Acceptable forms of proof are:

1. Certificate of Creditable Coverage from prior carrier, or
2. Copy of ID card or most recent payroll stub showing medical coverage deduction, or
3. Copy of most recent medical premium bill from prior carrier.

Failure to provide Proof of Prior Coverage may subject you or a family member to the full pre-existing conditions limitation with no credit for prior coverage. You may request a Certificate of Creditable Coverage from your prior carrier.

| Name of Covered Individual | Carrier Name | Group Number | Start Date | Termination Date | Health | Dental |
|---|---|---|---|---|---|---|
| | | | | | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ No | ☐ Yes ☐ No |

## G. Declination/Waiver of Coverage - *Check all that apply.*

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 | ☐ Disability | Reason for declining coverage (If applicable attach front/back of your health ID card):<br>☐ Covered by spouse's group coverage - Carrier Name and ID number: _____<br>☐ Enrolled in other insurance - Carrier Name and ID number: _____<br>☐ Spouse covered by employer's group insurance<br>☐ Medicare ☐ Tricare ☐ CHAMPVA ☐ Military ☐ Individual ☐ Do not want<br>☐ Other _____ |
| ☐ Spouse | ☐ Medical | ☐ Dental | ☐ Life | | |
| ☐ Child | ☐ Medical | ☐ Dental | ☐ Life | | |

I certify I have been given the right to apply for this coverage, however, I am waiving coverage as noted above. By declining this group coverage I acknowledge that myself and/or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage. Pre-existing conditions, when enrolled in this plan, may not be covered for twelve months.

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

## H. Race/Ethnicity - Optional (This information is designed for the purpose of data collection and will not be used for determining eligibility, rating or claim payment.)

| | | | |
|---|---|---|---|
| **Employee 1.** | ☐ White - 01 ☐ African American or Black - 02 ☐ Hispanic or Latino - 03 ☐ Asian - 04 ☐ Other - 05 _____ | **Child 3.** | ☐ White - 01 ☐ African American or Black - 02 ☐ Hispanic or Latino - 03 ☐ Asian - 04 ☐ Other - 05 _____ |
| **Spouse 2.** | ☐ White - 01 ☐ African American or Black - 02 ☐ Hispanic or Latino - 03 ☐ Asian - 04 ☐ Other - 05 _____ | **Child 4.** | ☐ White - 01 ☐ African American or Black - 02 ☐ Hispanic or Latino - 03 ☐ Asian - 04 ☐ Other - 05 _____ |

## I. Health Questionnaire for Groups Enrolling 2 - 9 Employees (Continued)

**Health History for Individuals and Their Dependents.** ***The following information is confidential and will not be seen by or given to your employer.***

- ALL of the questions must be answered by you and your dependents or the enrollment form will be returned.
- Incomplete enrollment forms may delay the effective date of your coverage.

**In the past five (5) years, has any person listed on the enrollment form seen a health care provider(s), had treatment recommended, received treatment, including prescription medications or been hospitalized for any of the following conditions listed below?**

| | | Yes | No |
|---|---|---|---|
| 1. | Heart attack, heart murmur, stroke, chest pain, high blood pressure, anemia, varicose veins or other disorders of the heart, blood, blood vessels or high cholesterol? | ☐ | ☐ |
| 2. | Ulcer, colitis, gallstones or any other disorder of the stomach, intestines, rectum, pancreas, liver or Hepatitis B/C? | ☐ | ☐ |
| 3. | Cancer, cyst or tumor? | ☐ | ☐ |
| 4. | Disorders of the kidneys, adrenal glands, thyroid glands, urinary systems, male or female organs, infertility, menstrual dysfunction or sexually transmitted disease (except AIDS/ARC)? | ☐ | ☐ |
| 5. | Asthma, emphysema, tuberculosis or any other disorders of the lungs or respiratory system? | ☐ | ☐ |
| 6. | Migraines, fainting spells, epilepsy, mental or nervous conditions, depression, paralysis or any disorder of the brain or nervous system? If epileptic, date of last seizure: ____/____/____ (month/day/year) | ☐ | ☐ |
| 7. | Lupus, arthritis, back trouble or any other disorder of the joints, muscles or bones, including prosthetic device or implants? | ☐ | ☐ |
| 8. | Any physical deformity, defect or congenital problem? | ☐ | ☐ |
| 9. | Has any person to be covered had or has been told they have an immune disorder, AIDS, or AIDS-Related Complex? | ☐ | ☐ |
| 10. | Has any person been treated for alcoholism, other drug or substance abuse, including use of any illegal or controlled drugs, or been advised to seek treatment for the same? | ☐ | ☐ |

*continued on next page*

**IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS IN SECTION I, YOU MUST COMPLETE SECTION K ON THE FOLLOWING PAGE.**

***If you are providing additional sheets, check here ☐ and insert the sheets before sealing this Enrollment form.***

## I. Health Questionnaire for Groups Enrolling 2 - 9 Employees (Continued)

| | Yes | No |
|---|---|---|
| 11. Has any person been diagnosed with diabetes? If Yes, list date of diagnosis: ___/___/___ (month/day/year) ..... | ☐ | ☐ |
| Insulin dependent? _____ Non-insulin dependent? _____ | | |
| 12. a. Is any female to be covered currently pregnant? If Yes, list due date: ___/___/___ (month/day/year) ..... | ☐ | ☐ |
| b. Have there been any complications thus far? ..... | ☐ | ☐ |
| c. Are multiple births expected? ..... | ☐ | ☐ |
| d. If you are a male listed on this enrollment form, are you expecting a child with anyone, even if the mother is not listed on this enrollment form? ..... | ☐ | ☐ |
| 13. Has any person taken any prescribed medications in the past 12 months? **If Yes, list below**. ..... | ☐ | ☐ |
| 14. Has any person had an abnormal physical exam or been advised to undergo further testing, surgery or treatment? ..... | ☐ | ☐ |
| 15. Has any person been a patient in a hospital, clinic, surgical center, sanatorium or medical facility as an outpatient or inpatient (excluding childbirth)? ..... | ☐ | ☐ |
| 16. Does anyone named on this enrollment form use tobacco products, including cigarette, pipe, cigar, or chewing tobacco? ..... | ☐ | ☐ |
| If Yes, check applicable boxes: ☐ Employee ☐ Spouse? | | |
| 17. Has any person had any medical condition or symptom not listed on this enrollment form? ..... | ☐ | ☐ |

**IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS IN SECTION I, YOU MUST COMPLETE SECTION K BELOW.**

## J. Health Questionnaire for Groups Enrolling 10 - 50 Eligible Employees

**Health History for Individuals and Their Dependents.** ***The following information is confidential and will not be seen by or given to your employer.***

- ALL of the questions must be answered by you and your dependents or the enrollment form will be returned.
- Incomplete enrollment forms may delay the effective date of your coverage.

| | Yes | No |
|---|---|---|
| 1. Within the last 24 months has anyone applying for coverage consulted, received treatment, by a doctor, psychiatrist, psychologist, or other practitioner or been diagnosed with any of the following conditions or disorders? (Check all that apply.) ..... | ☐ | ☐ |

*If a condition is not noted, please list it below in Section K.*

| | | |
|---|---|---|
| ☐ Diabetes | ☐ Paralysis/Paresis | ☐ Pituitary/Adrenal/Growth Disorder |
| ☐ Infertility | ☐ Tumor/Cyst/Growth | ☐ Arthritis/Bone/Joint/Muscle/Prosthetic Device |
| ☐ Endocrine | ☐ Systemic or Lupus | ☐ Mental/Nervous/Emotional/Eating |
| ☐ Pancreas | ☐ Lung or Respiratory | ☐ Stroke/Brain/Neurological/Central Nervous System |
| ☐ Liver/Hepatitis | ☐ Alcohol or Drug Use | ☐ Transplant (recommended, pending or complete) |
| ☐ Immune System | ☐ Kidney/Bladder/Urinary | ☐ Advised to have surgery or treatment is needed or pending |
| ☐ Cancer or Blood | ☐ Heart/Circulatory/Vascular | ☐ Had medical claims in excess of $5,000 |
| ☐ Epilepsy/Seizure | ☐ Digestive/Stomach/Intestinal | ☐ Currently pregnant – due date: ___/___/___ (month/day/year) |

☐ Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or tested positive for HIV

| | | | |
|---|---|---|---|
| 2. Has anyone applying for coverage been prescribed medications in the past 12 months? ..... | | ☐ | ☐ |
| 3. Does anyone applying for coverage have a known condition that requires on-going treatment? ..... | | ☐ | ☐ |
| 4. Do you or spouse use tobacco products, including cigarette, pipe, cigar, or chewing tobacco? ..... | | ☐ | ☐ |
| If Yes, check applicable boxes: | ☐ Employee ☐ Spouse | | |

**IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS IN SECTION J, YOU MUST COMPLETE SECTION K BELOW.**

## K. Health Questionnaire - Details for "Yes" Responses in Sections I and J.

**IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS IN SECTIONS I AND J, YOU MUST COMPLETE THE FOLLOWING.**

Please provide us with FULL DETAILS for each "Yes" answer to any condition(s) checked in Sections I and J. **In addition**, please give details below of last doctor visit and/or physical examination for **ALL** family members listed regardless of the date or reason. *(Insert additional sheets if necessary.)*

| Question Number | Name of Individual | Condition/Diagnosis | Date of Onset | Date Treatment Ended | Medication Prescribed | Dosage | Still Taking Medication |
|---|---|---|---|---|---|---|---|
| | | | | | | | ☐ Yes ☐ No |
| | | | | | | | ☐ Yes ☐ No |
| | | | | | | | ☐ Yes ☐ No |
| | | | | | | | ☐ Yes ☐ No |
| | | | | | | | ☐ Yes ☐ No |
| | | | | | | | ☐ Yes ☐ No |

***If you are providing additional sheets, check here ☐ and insert the sheets before sealing this Enrollment form.***

## Conditions of Enrollment

On behalf of myself and the dependents listed on the reverse side, 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 Choice® POS (Open Access) and Aetna Open Access HMO: Corporate Health Insurance Company and/or Aetna Health Inc.
   - Aetna Open Choice® PPO: Aetna Life Insurance Company
   - Life, Accidental Death & Dismemberment, 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 this enrollment form and the employer application have been accepted by Aetna. Even if this enrollment form is accepted, any intentional and material misstatements or omissions that amount to fraud may result in future claims being denied and my coverage under the policy being rescinded or reevaluated, as of the effective date, for eligibility and rating purposes except as otherwise provided by law.
   ***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.
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 to Aetna or its agent information concerning the medical history, services or treatment provided to anyone listed on this Enrollment 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 and competent adult dependents, and I have obtained their consent to those terms. Authorizations signed for the purpose of collecting information in connection with this application for an insurance policy, a policy reinstatement or a request for a change in policy benefits shall remain valid for thirty (30) months from the date it is signed. Authorizations signed for the purpose of collecting information in connection with a claim for benefits shall remain valid for the term of this coverage or for so long 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.
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 providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.
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.
7. I understand and agree that, as described in the plan documents, when enrolled for medical coverage other than an HMO plan, any pre-existing conditions for my spouse, dependents or myself may not be covered for 12 months.

## Misrepresentation

8. 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 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. I have read and agree to the Conditions of Enrollment, Authorizations and Misrepresentation on this Ohio Small Group Business (2-50 Eligible Employees) Employee Enrollment/ Change Form. I understand that, in the event I fail to sign this form within 31 days of my eligibility date 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 25 hours per week for this employer at the regular place of business.

| *Employee Signature* | *Spouse Signature (Optional - required only if enrolling)* | *Employee E-mail Address (optional)* | *Date (Mo./Day/Yr.)* |
|---|---|---|---|
| X | X | | |