Florida Employee Enrollment/Change Form
(For groups with 1 to 50 employees)

Aetna Vision℠ Preferred plans, Aetna Managed Choice plans and Aetna PPO plans are underwritten by Aetna Life Insurance Company. Aetna HMO plans and Aetna POS plans are underwritten by Aetna Health Inc. Aetna Dental plans are provided or administered by 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 B.** Please use only black ink to complete this form.

Group number

Aetna member ID number (if available)

Company name:

Effective date	☐ New hire ☐ Rehire / reinstatement ☐ New group enrollment ☐ Late enrollment ☐ Waiver ☐ Open enrollment ☐ Loss of coverage	☐ Add spouse ☐ Add domestic partner ☐ Add dependent child ☐ Change of coverage ☐ Name change	☐ Employee termination date: _____ ☐ Remove spouse ☐ Remove domestic partner ☐ Remove dependent child ☐ Cancel coverage ☐ Other _____
Date of hire			
Benefit waiting period* ☐ Class 1 ☐ Class 2 * Only required when your employer has 2 benefit waiting periods			

☐ **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 dependents, including spouse or domestic partner, enrolling for medical coverage
Number of hours worked a week	Check one: ☐ Full time ☐ Part time ☐ 1099 ☐ Retiree ☐ Seasonal ☐ Temporary ☐ COBRA ☐ Union			

B. 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 ☐ Vision	☐ Dental
☐ Spouse / domestic partner:	☐ Medical ☐ Vision	☐ Dental
☐ Child(ren):	☐ Medical ☐ Vision	☐ Dental

Reason for declining coverage

- ☐ Parental group coverage
- ☐ Spouse / domestic partner group coverage
- ☐ Medicare
- ☐ Medicaid
- ☐ Retiree coverage
- ☐ COBRA coverage
- ☐ Insurance through another job
- ☐ TRICARE / Military coverage
- ☐ Individual coverage – On Exchange
- ☐ Individual coverage – Off Exchange
- ☐ Another group plan provided by my employer
- ☐ Do not want
- ☐ Other _____

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)***

☐ I am declining coverage. **Employee signature:** X

Please PRINT employee name:

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

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

1. Medical:

☐ **Aetna HNOnly (HMO OA)** – Plan option _____

☐ **Aetna HNOption (POS OA)** – Plan option _____

☐ **Aetna Savings Plus (HMO GK)** – Plan option _____

☐ **Aetna Managed Choice Open Access** – Plan option _____

☐ **Aetna PPO** – Plan option _____

☐ **Other** – Plan option _____

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: ☐ Managed Dental *or* ☐ PPO

Voluntary plans – Plan number _____ Plan name _____

If FOC, choose: ☐ Managed Dental *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

Control/Group number	Suffix	Account	Plan number

3. Vision

Aetna Vision℠ Preferred ☐ Yes ☐ No

D. 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 mandates coverage of dependent children up to age 26, your plan may allow coverage beyond age 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	Dental provider office ID number	Current patient ☐ Yes

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

Continued on next page

D. Individuals covered *(Continued)*

3	☐ Add ☐ Change ☐ Remove	**Name** (Last, first, middle initial) ☐ **Child** ☐ **Stepchild** ☐ **Other** _____		Sex (M/F)	Social Security number
Birthdate (MM/DD/YYYY) / /		Incapacitated ☐ Yes ☐ No		Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision	
PCP provider ID number		Current patient ☐ Yes		Dental provider office 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) / /		Incapacitated ☐ Yes ☐ No		Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision	
PCP provider ID number		Current patient ☐ Yes		Dental provider office ID number	Current patient ☐ Yes

5	☐ Add ☐ Change ☐ Remove	**Name** (Last, first, middle initial) ☐ **Child** ☐ **Stepchild** ☐ **Other** _____		Sex (M/F)	Social Security number
Birthdate (MM/DD/YYYY) / /		Incapacitated ☐ Yes ☐ No		Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision	
PCP provider ID number		Current patient ☐ Yes		Dental provider office ID number	Current patient ☐ Yes

6	☐ Add ☐ Change ☐ Remove	**Name** (Last, first, middle initial) ☐ **Child** ☐ **Stepchild** ☐ **Other** _____		Sex (M/F)	Social Security number
Birthdate (MM/DD/YYYY) / /		Incapacitated ☐ Yes ☐ No		Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision	
PCP provider ID number		Current patient ☐ Yes		Dental provider office ID number	Current patient ☐ Yes

E. Dependent information

List any dependent in Section **D** with a different last name or 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 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

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 HMO and POS plans: Aetna Health Inc.
   - Aetna PPO and Managed Choice plans: Aetna Life Insurance Company
   - Aetna Vision℠ 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
   - Dental and 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 until Aetna has approved both my employee enrollment form and the employer applications.
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 health care professional, hospital or any other health care organization ("providers"), including pharmacies or pharmacy database benefit managers, to give to 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 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 twenty-four (24) months. 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. I may revoke my authorization to disclose nonpublic personal health information at any time. I can make this revocation by completing and returning to Aetna a Revocation of Authorization form that will be sent to me by Aetna upon my request. Aetna also will accept a form developed by my employer or my hand-written request for revocation of authorization. However, the employer form or my request must include all the data elements that are included in Aetna's standard revocation form. 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.
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.

To the best of my knowledge and belief, I represent that all information supplied in this form is true and complete. On behalf of myself and the eligible persons listed herein, I have read and understand this form in its entirety and agree to the conditions of enrollment and fraud statement 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. 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 and I agree to make any necessary payments required for coverage.

Fraud statement: Any person who knowingly and with intent to injure, defraud or deceive any insurer files an application for insurance or statement of claim containing any false, incomplete or misleading information Is guilty of a felony of the third degree.

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)***