Aetna®

Enrollment/Change Request

Aetna Health Inc.

Control	Suffix	Account	Plan Number

Group Number	Class Code

Employer Group Information (To Be Completed by Employer)

Group Name / Employer Name - Full Name of Business or Organization: SUTTER ROOFING

Continuation of Coverage, i.e., COBRA, State - *Not all options are available. Contact Employer for available options.*

Coverage For: ☐ Employee ☐ Dependents

Length of Continuation (months): ☐ 18 ☐ 36 ☐ Other _____

☐ 29 - Attach disability determination from the Social Security Admin.

Date of Loss of Coverage ___/___/___

Date of Qualifying Event ___/___/___

Continuation of Coverage Expiration Date ___/___/___

A. Type of Activity - Employee Completes Sections A - E. *Please Print Clearly.*

Instructions: Refer to the instructions on the back before completing this form. You must complete this application in full or it will be returned to you resulting in a delay in processing. You are solely responsible for its accuracy and completeness.

Enrollment

☐ New Enrollee/Subscriber

Effective Date: 10 / 01 / 2010

Date of Hire: ___/___/___

Change - *Check all that apply.*

☐ Add Spouse
☐ Add Dependent Child
☐ Name Change
☐ Other
☐ Change Plan _____
☐ Control/Suffix/Acct/Plan _____

Date of Event: ___/___/___

Reason: _____

Remove or Terminate - *Check all that apply.*

☐ Remove Spouse
☐ Remove Dependent Child
☐ Employee Withdrawal/ Termination

Effective Date: ___/___/___

Reason: _____

B. Employee Information

Social Security Number	Last Name, First Name, M.I.		Home Telephone ( )
Home Address	Apt. No.	City, State	ZIP Code
Employer Name			Work Telephone ( )
Work Address		City, State	ZIP Code

C. Plan Options - Your selection(s) must be offered by your employer.

☐ HMO ☐ QPOS®
☐ Aetna Open Access® HMO
☐ Aetna Choice® POS
☐ AHF Choice POS
☐ Aetna Health Network Option℠
☐ Aetna Health Network Only℠

Available options with Aetna Health Network Option and Aetna Health Network Only. Check all that apply.

☐ Aetna HealthFund™
☐ Aexcel®
☐ Aexcel® Plus

Indicate Plan Name

Primary Copay:
☐ $5 ☐ $10
☐ $15 ☐ Other $ _____

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage.

* *Provide details for "Yes" responses below.* Attach sheet to list additional children. Attach proof if full-time college student.

(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex M F	Birthdate MM DD YYYY	Social Security Number (If dependent has no SSN, write "None")	Other Medical Coverage Yes *	Other Rx Drug Coverage Yes *	Handicapped Yes N/A	Student Yes N/A	Primary Medical Office ID Number	Current Patient Yes	Dentist Office ID Number (If applicable)	Current Patient Yes
	Employee	☐ ☐	/ /		☐	☐				☐		☐
	Spouse	☐ ☐	/ /		☐	☐	☐	☐		☐		☐
	Child	☐ ☐	/ /		☐	☐	☐	☐		☐		☐
	Child	☐ ☐	/ /		☐	☐	☐	☐		☐		☐
	Child	☐ ☐	/ /		☐	☐	☐	☐		☐		☐

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.)

Code	Other

Using the KEY below, please identify the Race/Ethnicity code for each individual.

KEY: 01 - White
02 - African American or Black
03 - Hispanic or Latino
04 - Asian
05 - Other (Provide race/ethnicity in "Other" column at left)

1. If "Yes" to Other Medical Coverage above, provide effective dates, name & policy number of insurance carrier, HMO, or other source and your Member Identification Number.

2. If "Yes" to Other Rx Drug Coverage above, provide effective dates, name & policy number of insurance carrier, HMO, or other source and your Member Identification Number.

3. Does any dependent listed above live at a different address than the employee? ☐ Yes ☐ No If "Yes," who and what address?

Explain the circumstances:

4. If any dependent's last name differs from yours, explain the circumstances.

5. Is your spouse employed? ☐ Yes ☐ No If "Yes," provide name and address of spouse's employer.

E. Employee Signature ☐ *By checking this box you agree to use Aetna Navigator®, Aetna's member self-service website, for all future printed materials and understand you may choose to receive paper documents in the future.*

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

I certify that all information supplied in this form is true and complete to the best of my knowledge and/or belief. I have read and agree to the Conditions of Enrollment on the reverse side of this Enrollment/Change Request form.

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

Employee Signature *(Required)* X _____ Date ___/___/___ Employee E-mail Address _____ Primary Language Spoken _____

Employee copy may be used as a temporary ID card for 30 days from the effective date if authorized by employer. Coverage must be verified with Aetna prior to visiting a specialist or admission to a hospital.

Please make a copy for your records. visit us at www.aetna.com