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 that the health information page is not visible.

Illinois Group Business (2 - 50 Eligible Employees) Employee Enrollment/Change Form

Group Number
Member Aetna ID Number (if available)

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 F.**

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

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

1. Medical - Check applicable boxes. ☐ Employee ☐ Spouse/Civil Union Partner/Domestic Partner ☐ Child(ren)

- ☐ **HMO** - Plan Option: ______
- ☐ **Managed Choice® (Open Access)** - Plan Option: ______
- ☐ **Open Choice® PPO** - Plan Option: ______
- ☐ **Savings Plus** - Plan Option: ______
- ☐ **Idemnity** - Plan Option: ______
- ☐ **Other**: ______

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

2. Dental - Check applicable boxes. ☐ Employee ☐ Spouse/Civil Union Partner/Domestic Partner ☐ Child(ren)

To enroll, enter plan number and name elected below.

Standard Plans: Plan Number ______ Plan Name: ______ For *FOC, choose:* ☐ DMO® or ☐ PPO

Voluntary Plans: Plan Number ______ Plan Name: ______ For *FOC, choose:* ☐ 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 ☐ Short Term Disability ☐ 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

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

Social Security Number	Last Name, First Name, M.I.	Job Title	Home Telephone

Home Address	Apt. No.	City, State	ZIP Code

Work Address	City, State	ZIP Code	Work Telephone

Salary $ ☐ Hourly ☐ Monthly ☐ Weekly	Primary Language Spoken (Optional)	Number of Hours Worked Per Week	Check One: ☐ Full-Time ☐ 1099 ☐ Seasonal ☐ Part-Time ☐ Retired ☐ Temporary ☐ Union ☐ COBRA	Number of Dependents Including Spouse/Civil Union Partner/Domestic Partner

C. 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 dependent children up to age 26, your plan may allow coverage beyond these ages 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** ☐ **Civil Union Partner** ☐ **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	

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	

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 ☐ 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	

D. Dependent Information

List any dependent in Section **C** living at another address.	
Name	**Address**

For Life Coverage: If age 19 and over and a full-time student, provide information below.

Child Name	School Name	Expected Graduation Date	Number of Credit Hours

E. 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

F. 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

☐ **Spouse/Civil Union Partner/Domestic Partner:**
☐ Medical ☐ Dental ☐ Life

☐ **Child(ren):**
☐ Medical ☐ Dental ☐ Life

Reason for declining coverage

- ☐ Spousal group coverage
- ☐ Parental coverage
- ☐ Medicare
- ☐ Medicaid
- ☐ Retiree coverage
- ☐ Another group plan provided by my employer
- ☐ COBRA coverage
- ☐ Insurance through another job
- ☐ TRICARE or CHAMPVA
- ☐ Individual coverage – On or Off Exchange
- ☐ Do not want
- ☐ Other ___________________________

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.

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

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.)

- ☐ 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
- ☐ Clotting Disorder
- ☐ Congestive Heart Failure
- ☐ COPD using oxygen
- ☐ Cor Pulmonale
- ☐ Defibrillator /AICD/ Implantable Cardioverter
- ☐ Dialysis
- ☐ End of Life/Hospice
- ☐ Hemodialysis
- ☐ Morbid Obesity (BMI > 42)
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Myasthenia Gravis
- ☐ Paralysis
- ☐ Paraplegic
- ☐ Prosthesis present
- ☐ Pregnant - high risk or multiple births
- ☐ Quadriplegic
- ☐ Surgery scheduled or pending
- ☐ Other ___________________________

Name of Individual	Condition(s)

Conditions of Enrollment

On behalf of myself and the dependents listed on Page 2:

1. I acknowledge that by enrolling in the following plans, coverage is provided by the following entities (collectively referred to as "Aetna"):
   - Aetna HMO: Aetna Health Inc.
   - Aetna Managed Choice® Open Access and Open Choice® PPO: Aetna Life Insurance Company
   - Life, Accidental Death & Personal Loss, 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/Change Form and the employer application have been accepted by Aetna. Even if this Enrollment/Change 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 purposed 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. 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 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 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/civil union partner/domestic partner 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, 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 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.

I represent that all information supplied in this form is true and complete. I have read and agree to the Conditions of Enrollment and Misrepresentation on this **Illinois** Group Business 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	***Employee E-mail Address (optional)***	***Date (Month/Day/Year)***
X		