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 pages 2 and 3 are not visible.

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

Life, Accidental Death & Dismemberment, Disability, Aetna Managed Choice, and Aetna PPO plans are underwritten by Aetna Life Insurance Company. Aetna HMO and Aetna POS plans are underwritten by Aetna Health Inc. Dental plans are provided or administered by Aetna Life Insurance Company.

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 Section H.

Effective Date

Date of Hire

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

- ☐ 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

1. **Medical** - Check one.
   - ☐ Aetna HMO Open Access – Plan Option _____
   - ☐ Aetna HMO Gatekeeper – Plan Option _____
   - ☐ Aetna POS Open Access – Plan Option _____
   - ☐ Aetna Managed Choice Open Access – Plan Option _____
   - ☐ Aetna PPO – Plan Option _____

Control/Group No.	Suffix	Account	Plan No.

2. **Dental** - Check one.
   Standard Plans:
   - ☐ Aetna Dental™ Plan – Plan Option _____
   - ☐ Freedom of Choice: ☐ Managed Dental *or* ☐ PPO
   - ☐ Out-of-State PPO Plan

   Voluntary Plans:
   - ☐ Aetna Dental™ Plan – Plan Option _____
   - ☐ Freedom of Choice: ☐ Managed Dental *or* ☐ PPO
   - ☐ Out-of-State PPO Plan

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

Control/Group No.	Suffix	Account	Plan 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 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	Primary Language Spoken (Optional)

Home Address	Apt. No.	City, State	ZIP Code

Work Address	City, State	ZIP Code	Work Telephone

Salary	No. of Hours Worked Per Week	Check One	No. of Dependents Including Spouse
$ ☐ Hourly ☐ Weekly ☐ Monthly		☐ Full-Time ☐ Part-Time	

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	Relationship	Birthdate (MM/DD/YYYY)	Height (ft. in)	Weight (lbs)	Status	Coverage Election	PCP Provider ID Number
Employee							☐ Single ☐ Married ☐ Divorced ☐ Windowed ☐ Legally Separated	☐ Medical ☐ Dental ☐ Life/Dis	
			☐ Spouse ☐ Other _____				☐ Different Last Name	☐ Medical ☐ Dental ☐ Life	
Child			☐ Child ☐ Stepchild ☐ Other _____				☐ Different Last Name ☐ Lives at another address ☐ Full-Time Student (19+) ☐ Disabled (19+)	☐ Medical ☐ Dental ☐ Life	
Child			☐ Child ☐ Stepchild ☐ Other _____				☐ Different Last Name ☐ Lives at another address ☐ Full-Time Student (19+) ☐ Disabled (19+)	☐ Medical ☐ Dental ☐ Life	

D. 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 _____

E. Dependent Information

Does any dependent listed in Section C live at another address? ☐ Yes ☐ No If Yes, who and what address?	If any dependent's last name differs from yours, explain the circumstances.

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

G. 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	

H. 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.

Print Employee Name

☐ Employee	☐ Medical	☐ Dental	☐ Life	☐ Disability
☐ Spouse	☐ Medical	☐ Dental	☐ Life	
☐ Child(ren)	☐ Medical	☐ Dental	☐ Life	

Reason for declining coverage (If applicable attach front/back of your health ID card):

- ☐ Covered by spouse's group coverage - Carrier Name and ID number: _____
- ☐ Enrolled in other insurance (check applicable box):
  - ☐ Medicare ☐ TRICARE ☐ CHAMPVA ☐ Military ☐ Individual ☐ COBRA
  - ☐ Retiree ☐ Other _____
- ☐ Carrier Name and ID number: _____
- ☐ Spouse covered by employer's group coverage
- ☐ Do Not Want

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). X Employee Signature	*Date (Month/Day/Year)*

I. Health Questionnaire for Groups Enrolling 2 - 9 Eligible Employees (or 2 - 50 if enrolling for life above the Guarantee Issue amount) and All New Enrollees for Existing Groups with 2-50 Eligible Employees. All new business groups do not need to complete this section if they are eligible to complete the Group Medical Questionnaire.

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 or your application will be returned.
- Incomplete applications may delay the effective date of your coverage.

To the best of your knowledge and belief, in the past twenty-four (24) months, has any person listed on the application been diagnosed with, treated for, or had treatment recommended by a licensed member of the medical profession 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 gland, urinary system, 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. 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 ABOVE YOU MUST COMPLETE SECTION K ON THE FOLLOWING PAGE.

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

	Yes	No
10. Diabetes? If Yes, list date of diagnosis: ____/____/____ (month/day/year) ☐ Insulin dependent ☐ Non-insulin dependent	☐	☐
11. 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 application, are you expecting a child with anyone, even if the mother is not listed on this application?....	☐	☐
12. Has any applicant taken any prescribed medications in the past 12 months? If Yes, list below.....	☐	☐
13. Has any applicant been advised to undergo further testing, surgery or treatment?.....	☐	☐
14. Has any applicant been a patient in a hospital, clinic, surgical center, sanatorium or medical facility as an outpatient or inpatient (excluding childbirth)?	☐	☐
15. Do you or your spouse use tobacco products, including cigarettes, pipe, cigars, or chewing tobacco? ..... If Yes, check applicable boxes: ☐ Employee ☐ Spouse	☐	☐
16. Has any applicant had any medical condition not listed on this application?.....	☐	☐
Has any person listed on this enrollment form been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	☐	☐

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS ABOVE (EXCEPT LAST QUESTION), YOU MUST COMPLETE SECTION J BELOW.

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

J. Health Questionnaire - Details for "Yes" Responses in Section I.

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS IN SECTION I (EXCEPT LAST QUESTION IN SECTION I), YOU MUST COMPLETE THE FOLLOWING TO THE BEST OF YOUR KNOWLEDGE AND BELIEF.
Please provide us with FULL DETAILS for each "Yes" answer to any condition(s) checked in Section I. 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	Date of Onset	Date Treatment Ended	Medication Prescribed	Dosage	Still Taking Medication
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ 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:

1. I acknowledge that by enrolling in the following plans, coverage is provided by the following entities (collectively referred to as "Aetna"):
   - Aetna HMO plans: Aetna Health Inc.
   - Aetna POS plans: Aetna Health Inc.
   - Life, Accidental Death & Dismemberment, disability, dental 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 applications have been accepted and approved by Aetna. ***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/Change Request 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, prescription utilization history, services or treatment provided to anyone listed on this Enrollment/Change Request 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 and competent adult dependents, and I have obtained their consent to those terms. This authorization will remain valid for the term of the coverage and for so long thereafter 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 Managed Dental 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. 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 acknowledge that I have read and understand this form in its entirety.

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 **Florida** 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 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 25 hours per week for this employer at the regular place of business.

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	***Employee E-mail Address (optional)***	***Date (Month/Day/Year)***
X		