



Texas Small Group Business Employee Enrollment/Change Form

Social Security Number _____

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	<input type="checkbox"/> New Hire <input type="checkbox"/> Other _____ <input type="checkbox"/> Rehire/Reinstatement	<input type="checkbox"/> Change of Coverage <input type="checkbox"/> Add Spouse/Dependent Child <input type="checkbox"/> Name Change <input type="checkbox"/> Other _____	<input type="checkbox"/> Employee Termination <input type="checkbox"/> Remove Spouse/Dependent Child <input type="checkbox"/> Cancel Coverage	COBRA/State Continuation for: <input type="checkbox"/> Employee <input type="checkbox"/> Dependent Length of Continuation: <input type="checkbox"/> 18 <input type="checkbox"/> 36 <input type="checkbox"/> Other _____ Original Qualifying Event Date _____	
Date of Hire	<input type="checkbox"/> New Group Enrollment <input type="checkbox"/> Late Enrollment	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. <input type="checkbox"/> Aetna HMO Plan - Plan _____ <input type="checkbox"/> Aetna PPO Plan - Plan _____ <input type="checkbox"/> Aetna Indemnity Plan <input type="checkbox"/> Value Plan _____ <input type="checkbox"/> Packaged Dental/Life/Disability Plan _____					2. Dental - Check one. <input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2 <input type="checkbox"/> Option 3: ___ DMO or ___ PDN <input type="checkbox"/> Option 4 <input type="checkbox"/> Option 5 <input type="checkbox"/> Option 6 Before today, were you covered under this employer's dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No					3. Life and Disability <input type="checkbox"/> Basic Life / AD&D Ultra™ <input type="checkbox"/> Optional Dependent Life <input type="checkbox"/> Life and 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.

Member Aetna ID Number (if available) _____	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 \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	No. of Hours Worked Per Week _____	Check One <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single	No. of Dependents Including Spouse _____
Subscriber Primary Language (other than English) Primer Idioma del suscriptor (que no sea el Ingles) What is your primary Language _____ ¿Cuál es su primer idioma? _____		Subscriber Disability Do you have a disability which affects your ability to communicate or read? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please indicate the nature of your disability. _____		

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

(Add/Change/Remove)	Name (Last, First, M.I.)	Sex M/F	Social Security No.	Birthdate MM / DD / YYYY	Height (ft., in.)	Weight (lbs.)	Incapacitated Yes N/A	Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	Other Health Coverage Yes No	Other Dental Coverage Yes No	Student Age 19 or Older (for Life/AD&D only)	Primary Office ID Number (If applicable)	Current Patient	Dental Office ID Number (If applicable)	Current Patient
Employee	1.			/ /				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse	2.			/ /				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Child	3.			/ /				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Child	4.			/ /				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

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 <input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02 1. <input type="checkbox"/> Hispanic or Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____	Employee <input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02 1. <input type="checkbox"/> Hispanic or Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____
Spouse <input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02 2. <input type="checkbox"/> Hispanic or Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____	Spouse <input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02 2. <input type="checkbox"/> Hispanic or Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____

E. Other Insurance

If you have checked "Yes" to Other **Health** Coverage (Section C), provide name and policy number of insurance carrier, HMO, or other source, a copy of the insurance card and start date of the coverage.

If you have checked "Yes" to Other **Dental** Coverage (Section C), provide name and policy number of insurance carrier, HMO, or other source, a copy of the insurance card and start date of the coverage.

Is your Spouse Employed? If "Yes," provide name and address of spouse's employer.
 Yes No

continued on next page

After completion, sign, remove tape from inside pages, fold closed and press to seal, and submit to your employer.

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E. Other Insurance (Continued)

<p>PROOF OF PRIOR COVERAGE - IMPORTANT (Required)</p> <p>Does anyone enrolling on this enrollment form have prior coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered "yes", provide applicant names, start and end dates of prior coverage.</p> <p>_____</p> <p>_____</p> <p><i>Proof of coverage must accompany this enrollment form for pre-existing condition credit if enrolling in other than an HMO plan.</i></p>	<p>Acceptable forms of proof are:</p> <ol style="list-style-type: none"> 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. <p>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 if enrolling in other than an HMO plan. You may request a Certificate of Creditable Coverage from your prior carrier.</p>
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F. Dependent Information

<p>Does any dependent listed in Section C live at another address? If Yes, who and what address? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>If any dependent's last name differs from yours, explain the circumstances.</p>
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G. Declination/Waiver of Coverage - To be completed if medical and/or dental coverage is declined or refused by an eligible employee and/or their eligible family members.

<p>1. Medical Coverage Declined for: <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents</p> <p>2. Dental Coverage Declined for: <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents</p>	<p>Reason for Declining Coverage (If applicable, please attach front/back of your health coverage ID card.):</p> <p><input type="checkbox"/> Covered by spouse's group coverage - Carrier Name and ID Number: _____</p> <p><input type="checkbox"/> Enrolled in other Insurance Carrier Plans - Carrier Name and ID Number: _____</p> <p><input type="checkbox"/> Spouse covered by employer's group medical coverage <input type="checkbox"/> Spouse covered by employer's group dental coverage</p> <p><input type="checkbox"/> Medicare <input type="checkbox"/> Covered by TRICARE or CHAMPVA <input type="checkbox"/> Other (Explain): _____</p>
<p>I acknowledge I have been given the right to apply for this coverage, however, I am electing not to enroll. 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 other than an HMO plan, may not be covered for twelve months.</p>	
<p>Please sign here ONLY if you are declining coverage for yourself or dependent(s).</p>	
<p>X</p>	<p>Date (Month / Day / Year)</p>

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

In the past five (5) years, has any person listed on the application 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?	<input type="checkbox"/>	<input type="checkbox"/>
2. Ulcer, colitis, gallstones or any other disorder of the stomach, intestines, rectum, pancreas, liver or Hepatitis B/C?	<input type="checkbox"/>	<input type="checkbox"/>
3. Cancer, cyst or tumor?	<input type="checkbox"/>	<input type="checkbox"/>
4. Disorders of the kidneys, adrenal glands, thyroid glands, urinary systems, male or female organs, infertility, menstrual dysfunction or sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>
5. Asthma, emphysema, tuberculosis or any other disorders of the lungs or respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>
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)	<input type="checkbox"/>	<input type="checkbox"/>
7. Lupus, arthritis, back trouble or any other disorder of the joints, muscles or bones, including prosthetic device or implants?	<input type="checkbox"/>	<input type="checkbox"/>
8. Any physical deformity, defect or congenital problem?	<input type="checkbox"/>	<input type="checkbox"/>
9. Has any person to be covered had or has been told that they have an immune disorder, AIDS or AIDS related complex?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
11. Has any person been diagnosed with diabetes? If yes, list date of diagnosis: ____/____/____ (month/day/year)	<input type="checkbox"/>	<input type="checkbox"/>
Insulin dependent? _____ Non-insulin dependent? _____		
12. a. Is any female to be covered currently pregnant? If yes, list due date: ____/____/____ (month/day/year)	<input type="checkbox"/>	<input type="checkbox"/>
b. Have there been any complications thus far?	<input type="checkbox"/>	<input type="checkbox"/>
c. Are multiple births expected?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>

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H. Health Questionnaire (Continued)

- 13. Has any applicant taken any prescribed medications in the past 12 months? If yes, list below.
14. Has any applicant had an abnormal physical exam or been advised to undergo further testing, surgery or treatment?
15. Has any applicant 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 application use tobacco products, including cigarette, pipe, cigar, or chewing tobacco?
17. Has any applicant had any medical condition or symptom not listed on this application?

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS ON SECTION H, YOU MUST COMPLETE THE FOLLOWING.

Please provide us with FULL DETAILS for each "Yes" answer to any condition(s) checked on Page 2. 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.)

Ques. #: [] Name of Applicant: Name of Illness/Condition:
Date of Onset: Month Year Date Treatment Ended: Month Year Still under Treatment: Yes No
Medication: Date Prescribed: Month Year Dosage:
Treatment Given:

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Date of Onset: Month Year Date Treatment Ended: Month Year Still under Treatment: Yes No
Medication: Date Prescribed: Month Year Dosage:
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Date of Onset: Month Year Date Treatment Ended: Month Year Still under Treatment: Yes No
Medication: Date Prescribed: Month Year Dosage:
Treatment Given:

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 HMO Plan: Aetna Health Inc.
 - Aetna Dental DMO: Aetna Dental Inc.
 - Life, 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 and employer applications have been accepted and approved by Aetna. Even if this enrollment form is approved, any misstatements or omissions may result in future claims being denied and the policy or my coverage under the policy being rescinded or reevaluated, as of the effective date, for eligibility and rating purposes.

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") 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 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. I understand that this authorization is provided under state law and that it is not an "authorization" within the meaning of the federal Health Insurance Portability and Accountability Act. 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 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 and when enrolled for medical coverage in other than an HMO plan, any pre-existing conditions for my spouse, dependents or myself may not be covered for 12 months.

Misrepresentation

8. It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. In addition, an insurer may deny insurance benefits if false information materially related to the claim was provided by the applicant.

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 Texas Small Group Business 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, usually 30 hours per week, for this employer at the regular place of business.

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

<i>Employee Signature</i> X	<i>Spouse Signature</i> X	<i>Employee E-mail Address (optional)</i>	<i>Date (Mo/Day/ Yr)</i>
<i>Employer Signature</i> X			<i>Date (Mo/Day/ Yr)</i>