Enrollment/Change Request
Aetna Life Insurance Company

Aetna US Healthcare

A. Transaction Information — EFFECTIVE DATE (MM/DD/YR)

1. Enrollment (Check One)

☐ New Enrollee
Hire Date ___ / ___ / ___ (MM DD YR)

☐ Rehired/Reinstatement
Date ___ / ___ / ___ (MM DD YR)

☐ Return to Work
Date ___ / ___ / ___ (MM DD YR)

2. Change

	From	To
☐ Social Security Number		
☐ Control/Suffix/Acct (B.2.)		

☐ Stop Continuation of Health Coverage (i.e., COBRA)
☐ Other ___

3. Termination

☐ Terminating Employment - Reason ___
☐ Cancelling Coverage - Reason ___
☐ Continue Employee Health Coverage (i.e., COBRA)
☐ Continue Dependent Health Coverage (i.e., COBRA)

Check One: ☐ Elect Choice® EPO ☐ Select Choice® HMO ☐ Managed Choice® POS ☐ Traditional Choice® ☐ Open Choice® PPO ☐ Other ___

B. Employer Information

1. Employer Name - Full Name of Business or Organization	2. Control No.	Suffix	Account	3. Plan Number	4. Group Number (HMO Only)	5. SFO
DOD NAF HEALTH BENEFIT PROGRAM	0721027	013				0098

6. Employer Address (Street, City, State, ZIP Code) - Primary Location of Business or Organization	7. Claim Office Code	8. Customer Code (Optional)	9.
4700 KING STREET - 3RD FLOOR ALEXANDRIA, VA 22302-4407	018		Network ID ___

C. Employee Information - Please Print All Information

1. Employee Social Security Number	2. Employee Name (Last, First, Middle Initial)	3. Employee Home Address (Number, Street, Apt; City; State; ZIP Code)

4. Employee Status	5. Sex	6. Home Telephone Number	7. Work Telephone Number
☐ Active ☐ Retired		( )	( )

8. Beneficiary Designation - **Full Beneficiary Name** (First, Middle, Last) If more than one beneficiary, use Special Remarks.	Social Security Number of Beneficiary	Relationship to Employee	9. Earnings
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXX	☐ Annually $ XXXXXXX ☐ Weekly $ XXXXXXX ☐ Insurance Amount $ XXXXXXX ☐ Supplemental Life $ XXXXXXX ☐ AD&D Amount $ XXXXXXX

D. Individuals Covered (List individuals for whom you are electing/changing coverage.) ☐ **Check this box if you are refusing coverage for your dependents.**

(A)dd/New (C)hange (R)emove	Relation. Code	Name (First, Middle Initial, Last) (Explain difference in last names in Special Remarks)	Social Security Number (If dependent has no SSN, write "None")	Birthdate MM / DD / YYYY	Dependent Address (If different than employee)	Prior Insur. Plan	Other Health Coverage	Currently Covered by Medicare	Handi-capped	Student Age 19 or Older	Primary Care Provider ID # / Primary Care Provider Name	Prev. Seen
	Self			/ /	Not Applicable	Yes* ☐	Yes* ☐	Yes ☐	Yes* N/A	Yes* N/A	ID # ___ Name ___	Yes ☐
				/ /		☐	☐	☐	☐	☐	ID # ___ Name ___	☐
				/ /		☐	☐	☐	☐	☐	ID # ___ Name ___	☐
				/ /		☐	☐	☐	☐	☐	ID # ___ Name ___	☐
				/ /		☐	☐	☐	☐	☐	ID # ___ Name ___	☐

Special Remarks

E. Acknowledgments - Signatures Required

I have read and agree to the terms of the authorization on the back of this Enrollment/Change Request form. I understand that, in the event I fail to sign this form within 31 days after the above transaction request or that 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.

Employee Signature X ___ Date ___ **Employer Signature** X ___ Date ___

Instructions - Instructions are provided only for those fields which are not self-explanatory or for which you may need additional information.

(✓) In the area designated "Check One" in the upper left corner of the form, check box to confirm coverage requested. "Other Coverage" may include **Life Only** or **Dental Only.**

A. Transaction Information

*Make sure you complete the **Effective Date** in the upper right corner of the form.*

*Make sure you read Section E. **Sign name and date.***

To Enroll

- Complete **Effective Date** and check appropriate box in Section **A**, Number **1.**
- Complete blank fields in Section **B** (if applicable).
- Complete Section **C**, Numbers **1** through **9.**
- Complete Section **D** for all individuals for whom you are electing coverage. Complete **ALL** items for each individual listed.
- Complete **Primary Care Provider (PCP) ID# and Name** (Section **D**) if you have chosen Elect Choice, Managed Choice or Select Choice.

To Change

- Complete **Effective Date** and check appropriate box in Section **A**, Number **2**.
- Complete blank fields in Section **B** (if applicable).
- Complete Section **C**, Numbers **1** and **2.**
- Indicate change(s) in appropriate Section(s) (**B, C, D**) and *circle*.
- Check "Other" for dependent coverage cancellation and indicate individual(s) in Section **D**.

To Terminate

- Complete **Effective Date** and check appropriate box in Section **A**, Number **3**.
- Indicate reason for Termination or Cancellation.
- Check appropriate box for individuals continuing health coverage. **Note:** Section D must be completed for all individuals continuing coverage.

B. Employer Information

The Group Number (B4), Servicing Field Office (B5) and Claim Office Code (B7) are assigned by Aetna.

B2. **Control, Suffix and Account** - If this information is not preprinted, provide the complete Control, Suffix and Account numbers.

B3. **Plan Number** - If this information is not preprinted, refer to the Plan Sheet to determine the correct Plan Number.

B8. **Customer Code (Optional)** - Provide an identifying Customer Code for the employee only if you had elected to provide this information.

B9. **Network ID** - If you have chosen Elect Choice, Managed Choice or Select Choice record the Network ID number from the *Provider Directory*.

C. Employee Information

To be completed by the Enrollee.

C8. **Beneficiary Designation** - *Full Beneficiary Name (First, Middle and Last)*, Social Security Number and relationship of the person to whom benefits will be paid in the event of your death.

C9. **Earnings** - Consult your Benefits Administrator to identify if earnings/insurance amounts need to be reported. Check the appropriate box and enter the rounded dollar amount.

D. Individuals Covered

To be completed by Enrollee.

List only those individuals for whom you are electing/ changing coverage and complete ALL items for each individual listed.

- **Add/Change/Remove** - Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- **Relationship Code** - Use **ONLY**: H=Husband, W=Wife, N=Divorced Spouse, S=Son, D=Daughter, Y=Sponsored Male, X=Sponsored Female. **If the dependent is NOT a biological or legally adopted child, please indicate relationship to employee in Special Remarks.**
- **Name** - This **must** be completed for all individuals for whom you are electing or changing coverage. Please complete **ALL** items in Section **D** for each individual listed. Attach another form if you are requesting coverage for additional dependents.
- **Birthdate** - Date of birth should include **four digit year of birth**.

* **Prior Insurance Plan** - Check "Yes" if you are covered under your employer's or other prior insurance plan. NOTE: You must provide the following in Special Remarks: **Carrier/Plan Name, effective date of prior coverage, policy/group number, and prior coverage type (i.e., individual or group)**.

* **Other Health Coverage** - Check "Yes" if you are currently covered by another health insurance plan. NOTE: You must provide the following in Special Remarks: **Carrier Name**.

- **Currently Covered by Medicare** - Check "Yes" based on employee/dependent(s) age or disabled status.

* **Handicapped** - Check "Yes" if handicapped and financially dependent, provide proof of handicapped status from the attending physician.

* **Student Age 19 or Older** - Defined as: Unmarried dependent child age 19 or older (refer to your Summary Coverage), regularly attends school and depends solely on the enrollee for support. Member Services may request that you provide proof from the educational institution.

- **Primary Care Provider (PCP) ID#/PCP Name** - This **must** be completed if you have chosen Elect Choice, Managed Choice or Select Choice. The PCP ID#s and PCP Names are listed in the *Provider Directory*. Check "Yes" if the PCP has been previously seen.

E. Acknowledgments

Signature Required.

- Read the information contained above the space provided for your signature and the **Authorization of Enrollee** on the back of the form.
- **Sign and date the form.**

Authorization of Enrollee

Disclosure of Healthcare Information	I authorize any physician, other healthcare professional, hospital, other healthcare institution and my employer to disclose, at any time and to the extent allowed by law, to Aetna Life Insurance Company or an affiliated entity ("Aetna"), information concerning healthcare (including dental) advice, treatment or supplies provided to my spouse or dependents or to myself, including those involving mental health, substance abuse and HIV/AIDS ("healthcare information").
Redisclosure of Healthcare Information	I also authorize Aetna to redisclose the healthcare information to my employer, healthcare professionals and institutions, independent claims administrators, utilization review organizations and reinsurers or other insurers with which Aetna has contracted.
Purpose of Disclosure/ Redisclosure	The healthcare information will be used for the coordination of patient care, administration of benefits, quality management and audit of services, and for fulfilling obligations imposed on Aetna by contract or law.
Dependents' Authorization	I have discussed the terms of this authorization with my spouse and competent adult dependents, and I have obtained their consent to the release of their healthcare information pursuant to this authorization.
Insured's Rights	I understand that I may review and offer corrections to the healthcare information, except information about me or my dependents that relates to claims or civil or criminal proceedings involving me or my dependents. I also understand I may revoke this authorization at any time, except to the extent it has been relied on by Aetna or other party. In addition, I understand that I may receive a copy of this authorization and that a copy of this authorization is as valid as the original.
Duration of Authorization	This authorization shall remain valid for the term of this coverage or for so long as allowed by law.
Payroll Deductions and Other Payments	I request the coverage which I have indicated and for which I am eligible. I authorize deductions from my earnings for any contributions required for healthcare coverage, and I agree to make any necessary payments as required for coverage.
Misrepresentations	I understand it is unlawful for me or my dependents to knowingly provide false, incomplete or misleading facts or information to Aetna for the purpose of defrauding or attempting to defraud Aetna. Penalties my include imprisonment, fines, denial of coverage, rescission of benefits, and legal damages.
Independent Contractors	Applicant acknowledges that Aetna Life Insurance Company's participating providers, including all participating primary care physicians, are independent contractors and are not agents or employees of Aetna Life Insurance Company.