



New York Employee Enrollment/Change Form (51 – 100 Eligible Employees)

Aetna Life Insurance Company

151 Farmington Avenue
Hartford, CT 06156
888-802-3862

Life, Accidental Death & Dismemberment; Aetna EPO plans; Aetna Indemnity; and Aetna Managed Choice Plan PPO are provided by Aetna Life Insurance Company. DMO® and PPO dental plans are provided 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 Sections B and C.			
Effective Date	<input type="checkbox"/> New Hire <input type="checkbox"/> Rehire/Reinstatement <input type="checkbox"/> New Group Enrollment <input type="checkbox"/> Late Enrollment <input type="checkbox"/> Other _____	<input type="checkbox"/> Change of Coverage <input type="checkbox"/> Add Spouse/Domestic Partner/Dependent Child <input type="checkbox"/> Name Change <input type="checkbox"/> Other _____	<input type="checkbox"/> Employee Termination <input type="checkbox"/> Remove Spouse/Domestic Partner/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					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					2. Dental					3. Life and Disability		
Open Access Elect Choice® (OA EPO) Plan Option: _____ Open Access Managed Choice® (OA MC) Plan Option: _____ Open Access Managed Choice® (OA MC) HSA Compatible Plan Option: _____ Open Access Managed Choice® (OA MC) HRA Plan Option: _____ Indemnity Plan Option: _____					Standard Plans: Option: _____ FOC: DMO® <input type="checkbox"/> or PPO <input type="checkbox"/> Voluntary Plans: Option: _____ FOC: DMO® <input type="checkbox"/> or PPO <input type="checkbox"/> Before today, were you covered under this employer's dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> Basic Life <input type="checkbox"/> Basic AD&D Ultra® <input type="checkbox"/> Optional Life <input type="checkbox"/> Optional Spouse Life <input type="checkbox"/> Optional Child Life <input type="checkbox"/> Optional AD&D Ultra® <input type="checkbox"/> Short Term Disability <input type="checkbox"/> Long Term Disability		
										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	
No. of Hours Worked Per Week	Check One <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single	No. of Dependents Including Spouse/Domestic Partner	

C. 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.

1. Medical Coverage Declined for: <input type="checkbox"/> Myself <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Dependents 2. Dental Coverage Declined for: <input type="checkbox"/> Myself <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Dependents	Reason for Declining Coverage (If applicable, please attach front/back of your health coverage ID card.): <input type="checkbox"/> Covered by spouse/domestic partner's group coverage - Carrier Name and ID _____ <input type="checkbox"/> Enrolled in other Insurance Carrier Plans - Carrier Name and ID _____ <input type="checkbox"/> Medicare <input type="checkbox"/> Covered by TRICARE or CHAMPVA <input type="checkbox"/> Other _____ <input type="checkbox"/> Spouse/Domestic Partner covered by employer's group medical coverage <input type="checkbox"/> Spouse/Domestic Partner covered by employer's group dental coverage
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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.

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

D. 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 age 26 for medical plans and some dental plans. Some exceptions apply. Please refer to your plan documents or contact your benefits administrator.

Name (Last, First, M.I.)	Sex M/F	Social Security Number	Birthdate (MM/DD/YYYY)	Coverage Election	Other Health Coverage	Other Dental Coverage	Prior Dental Coverage	Out of Area	Student (Life 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/Dis	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes N/A	Yes N/A		Yes <input type="checkbox"/>		Yes <input type="checkbox"/>
Spouse/Domestic Partner 2.				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A N/A			<input type="checkbox"/>		<input type="checkbox"/>
Child 3.				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Child 4.				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>

E. Dependent Information

Does any dependent listed in Section D live at another address? If Yes, who and what address?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If any dependent's last name differs from yours, explain the circumstances.
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Conditions of Enrollment

On behalf of myself and the dependents listed on the reverse side, I agree to or with the following:

- I acknowledge that by enrolling in an Aetna plan(s) on Page 1, coverage is provided by Aetna Life Insurance Company (referred to as "Aetna").
- I understand 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 application have been accepted and approved by Aetna. Even if this enrollment form is approved, any material misstatements or omissions may result in future claims being contested and the policy or my coverage under the policy being contested.
For life 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. Further, I understand that any insurance in excess of the plan's Guaranteed Issue Amount or that for any insurance which I am electing more than 31 days after I was first eligible to enroll for the insurance is subject to evidence of good health or medical information will not become effective until Aetna gives its written consent. Life insurance is incontestable after two years from date of issue, except for non-payment of premiums. Please review the Summary of Coverage document for more information.
- I understand and agree that: this enrollment form may be transmitted to Aetna or its agent by my employer or its agent.
- The plan certificate of coverage will determine the rights and responsibilities of member(s). It will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
- 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.
- I understand and agree that: with certain exceptions described in the plan documents, 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 dentist or by the participating dentist or other provider as authorized by a referral from a participating primary care dentist.

I represent that to the best of my knowledge and belief all information supplied in this form is true and complete. I have read and agree to the Conditions of Enrollment and Misrepresentation on this **New York** (51 – 100 Eligible Employees) Employee Enrollment/Change Form. I understand that if I do not sign this form within 31 days from the date first eligible or 31 days of the qualifying life event (i.e., marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.) I will be considered a late enrollee and the effective date of coverage for me and my dependents may be affected. I understand that any life insurance above a certain amount or for which I am electing as a late enrollee will not be effective until Aetna gives its written consent. I am employed by the employer shown on Page 1, and I am working full time at least 20 hours per week for this employer at the regular place of business.

Misrepresentation (This fraud warning is not applicable to an application for life insurance.)

Any person who knowingly and with intent to defraud any insurance company or other person files an application 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, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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

This form is attached to and made a part of the group policy.

Employee Name: _____

SSN: _____

Name (Last, First, M.I.)	Sex M/F	Social Security Number	Birthdate	Coverage Election	Student Age (Life Only)	Out of Area	Primary Office Number	Current Patient	Dental Office Number	Current Patient
					Yes	Yes		Yes		Yes
Child 5.				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Child 6.				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Child 7.				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Child 8.				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Child 9.				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Child 10.				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Child 11.				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Child 12.				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Child 13.				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Child 14.				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Child 15.				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Child 16.				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Child 17.				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Child 18.				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Child 19.				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Child 20.				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>