



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

Member Aetna ID Number (if available)

Employer Name _____ **INSTRUCTIONS:** You, the employee, must complete this application 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, E and F.**

Effective Date	<input type="checkbox"/> New Group Enrollment	<input type="checkbox"/> Late Enrollment	<input type="checkbox"/> Add Spouse/Dependent Child	<input type="checkbox"/> Employee Termination	COBRA / Cal-COBRA 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 _____ Reason _____
Date of Hire	<input type="checkbox"/> New Hire	<input type="checkbox"/> Other _____	<input type="checkbox"/> Change of Coverage	<input type="checkbox"/> Remove Spouse/Dependent Child	
	<input type="checkbox"/> Rehire/Reinstatement		<input type="checkbox"/> Name Change	<input type="checkbox"/> Other _____	

A. Coverage Selection - Please print clearly, using black ink. (Shaded sections for Employer/Aetna Use Only)

1. Medical - Check one. <input type="checkbox"/> Aetna Primary Care™ Plan HMO <input type="checkbox"/> Aetna Choice™ Plan (MC) <input type="checkbox"/> Aetna Choice™ Plan PPO <input type="checkbox"/> Aetna Direct™ Plan				2. Dental - Check one. <input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2: ___ DMO or ___ PPO <input type="checkbox"/> Option 3: ___ DMO or ___ PPO				3. Life and AD&D <input type="checkbox"/> Basic Life / AD&D Ultra™ <input type="checkbox"/> Optional Dependent Life				
Control/Group No.	Suffix	Account	Plan No.	Class Code	Control/Group No.	Suffix	Account	Plan No.	Control/Group No.	Suffix	Account	Plan No.

B. Employee Information - Must be completed by the employee.

Social Security Number	Last Name, First Name, M.I.	Occupation	Home Telephone ()	Life Insurance Beneficiary Designation - Full Beneficiary Name (First, Middle, Last) Social Security No. of Beneficiary _____ Relationship to Employee _____
Home Address	Apt. No.	City, State	ZIP Code	
Work Address	City, State	ZIP Code	Work Telephone ()	

C. Individuals Covered - List individuals for whom you are enrolling or adding/changing/removing coverage. Insert 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	Coverage Election		Other Health Coverage	Other Dental Coverage	Student Age 19 or Older	Provider ID Number (If applicable)	Current Patient	Dental Office ID Number (If applicable)	Current Patient	
								Medical	Dental								
Employee				/ /			Yes	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	Yes	Yes	Yes	N/A	Yes			Yes	
Spouse				/ /				<input type="checkbox"/> Medical <input type="checkbox"/> Dental				N/A					
				/ /				<input type="checkbox"/> Medical <input type="checkbox"/> Dental									
				/ /				<input type="checkbox"/> Medical <input type="checkbox"/> Dental									

D. Dependent Information

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	Explain the circumstances.	If any dependent's last name differs from yours, explain the circumstances.
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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.	PROOF OF PRIOR COVERAGE - IMPORTANT (Required) <i>Proof of coverage must accompany this application for pre-existing condition credit.</i> Acceptable forms of proof are: 1. Certificate of Creditable Coverage from prior carrier, or 2. Copy of ID card and 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.
If you have checked "Yes" to Other Dental Coverage (Section C), provide name and policy number of insurance carrier, HMO, or other source.	
Is your Spouse Employed? If "Yes," provide name and address of spouse's employer. <input type="checkbox"/> Yes <input type="checkbox"/> No	

F. 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 <input type="checkbox"/> Dependents 2. Dental Coverage Declined for: <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents 3. Life Coverage Declined for: <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents	Reason for Declining Coverage: <input type="checkbox"/> Covered by spouse's group coverage - Carrier Name and ID Number: _____ <input type="checkbox"/> Enrolled in other Insurance Carrier Plans - Carrier Name and ID Number: _____ <input type="checkbox"/> Spouse covered by employer's group medical coverage <input type="checkbox"/> Spouse covered by employer's group dental coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Covered by Champus or Champva <input type="checkbox"/> Other (Explain): _____
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For medical coverage, I understand that if I enroll at a later date as a late enrollee, coverage will be deferred until the plan anniversary date of the group.

Employee Signature if declining coverage for employee/dependent(s) - Required X	Date (Month / Day / Year)
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After completion, sign, remove tape from inside pages, fold closed and press to seal, and submit to your employer.

G. Health Questionnaire for Groups with 2 - 10 Eligible Employees

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 (except HIV infection), 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 or 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 deficiency disorder (except HIV), 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"/> |
| 13. Has any applicant taken any prescribed medications in the past 12 months? If yes, list below. | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Has any applicant had an abnormal physical exam or been advised to undergo further testing, surgery or treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Has any applicant been a patient in a hospital, clinic, surgical center, sanatorium or medical facility as an outpatient or inpatient (excluding childbirth)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Does anyone named on this application use tobacco products, including cigarette, pipe, cigar, or chewing tobacco? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Has any applicant had any medical condition or symptom not listed on this application? | <input type="checkbox"/> | <input type="checkbox"/> |

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS ABOVE, YOU MUST COMPLETE THE FOLLOWING.

Please provide us with FULL DETAILS for each "Yes" answer to any condition(s) checked above. **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:** _____
 Physician's Name: _____ Physician's Telephone Number: (____) _____
 Date of Onset: Month ____ Year ____ Date Treatment Ended: Month ____ Year ____ Still under Treatment: Yes No
 Medication: _____ Date Prescribed: Month ____ Year ____ Dosage: _____
 Treatment Given: _____

Ques. #: [] Name of Applicant: _____ **Name of Illness/Condition:** _____
 Physician's Name: _____ Physician's Telephone Number: (____) _____
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 Physician's Name: _____ Physician's Telephone Number: (____) _____
 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.

H. Health Questionnaire for Groups with 11 - 50 Eligible Employees

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, have you, your spouse or any of your dependents:

Yes No

- | | | | | | | | | | | | | | |
|--|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <ol style="list-style-type: none"> Had, consulted for, had treatment rendered, been advised to have treatment or been hospitalized for any of the following: Cardiovascular disease or heart attack, stroke; disorder of the kidneys, stomach, intestines or liver; musculoskeletal conditions; mental or nervous condition; central nervous system disorder; diabetes; any disorder of the lungs or respiratory system; cancer or immune deficiency disorder (except HIV), AIDS, or AIDS-related complex? Have you or any dependents to be covered visited a health care professional for any illness and/or medical condition resulting in medical expenses more than \$5,000 in the past 24 months? Have you or any dependent to be covered been advised in the last 12 months that hospitalization, surgery or treatment is needed or pending? <ol style="list-style-type: none"> Is any female to be covered currently pregnant? 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? Does anyone listed on this application use tobacco products, including cigarette, pipe, cigar, or chewing tobacco? | <table border="0"> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | |

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS ABOVE, YOU MUST COMPLETE THE FOLLOWING.

Please provide us with FULL DETAILS for each "Yes" answer to any condition(s) checked above. **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:** _____
 Physician's Name: _____ Physician's Telephone Number: (____) _____
 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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 Physician's Name: _____ Physician's Telephone Number: (____) _____
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 Physician's Name: _____ Physician's Telephone Number: (____) _____
 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 (continued on Page 4)

NOTICE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

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 the following plans, coverage is provided by the following entities (collectively referred to as "Aetna"):
 - Aetna Primary Care Plan HMO: Aetna of California Inc.
 - Aetna Dental DMO: Aetna Dental Plan of California Inc.
 - Life, disability, dental and all other health coverages: Aetna Life Insurance Company
- 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 application is approved, any misstatements or omissions may result in future claims being denied and the policy or your coverage under the policy being rescinded or reevaluated, as of the effective date, for eligibility and rating purposes. **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 and that the effective date of insurance for any of

Conditions of Enrollment (continued from Page 3)

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 Application 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 Application, including those involving mental health, substance abuse and AIDS or AIDS-related complex. 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 neither a "consent" nor 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 providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.
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.

Authorizations

7. I authorize deductions from my earnings for any contributions required for coverage, and I agree to make any necessary payments as required for coverage.
8. I authorize the substitution of generic pharmaceuticals for the brand-name products, as provided by law, for prescriptions filled under any pharmacy benefit.

Misrepresentation

9. Attention California Residents: For your protection, California law requires notice of the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

I represent that all information supplied in this form is true and complete. I have read and agree to the Conditions of Enrollment, Authorizations and Misrepresentation on this California Small Group Business (2 - 50 Eligible Employees) Employee Enrollment/Change Form. I understand that in the event I fail to sign and return this form to my employer within either the open enrollment period or 31 days after eligibility for enrollment or request for coverage change, or if for any reason Aetna does not receive notice of the above transaction request within a reasonable time following eligibility to enroll in or change coverage, 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 20 hours per week for this employer at the regular place of business.

NOTICE OF BINDING ARBITRATION: ANY DISPUTE ARISING FROM OR RELATED TO HEALTH PLAN MEMBERSHIP WILL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION, AND NOT BY A LAWSUIT OR RESORT TO COURT PROCESS EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. THE AGREEMENT TO ARBITRATE INCLUDES, BUT IS NOT LIMITED TO, DISPUTES INVOLVING ALLEGED PROFESSIONAL LIABILITY OR MEDICAL MALPRACTICE, THAT IS, WHETHER ANY MEDICAL SERVICES COVERED BY THIS AGREEMENT WERE UNNECESSARY OR WERE UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED. THE HEALTH PLAN AGREEMENT ALSO LIMITS CERTAIN REMEDIES AND PRECLUDES THE AWARD OF PUNITIVE DAMAGES. SEE THE EVIDENCE OF COVERAGE FOR FURTHER INFORMATION.

I understand that I am giving up the constitutional right to have disputes decided in a court of law before a jury, and instead am accepting the use of binding arbitration. This means that members will not be able to try their case in court. I further understand that the agreement contains limitations on certain remedies and that members cannot recover punitive damages.

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