



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

Member Aetna ID Number (if available)

Employer Name		<b>INSTRUCTIONS:</b> 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. <b>If waiving coverage, please complete Sections B and G.</b>					
Effective Date	<input type="checkbox"/> New Hire <input type="checkbox"/> Rehire/Reinstatement	<input type="checkbox"/> Other _____	<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.
<b>1. Medical</b> - Check one. <input type="checkbox"/> Aetna HMO Plan - Plan _____ <input type="checkbox"/> Aetna QPOS Plan/Open Access POS Plan - Plan _____ <input type="checkbox"/> Aetna Open Access MC Plan - Plan _____ <input type="checkbox"/> Aetna PPO Plan - Plan _____ <input type="checkbox"/> Aetna Indemnity Plan				<b>2. Dental</b> - Check one. <input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2 <input type="checkbox"/> Option 3: <input type="checkbox"/> DMO or <input type="checkbox"/> PPO <input type="checkbox"/> Option 4 <input type="checkbox"/> Option 5 <input type="checkbox"/> Option 6 <input type="checkbox"/> Out-of-State PPO				<b>3. Life and Disability</b> <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 (Last, First, Middle) _____ Beneficiary Social Security No. _____ Relationship to Employee _____				
<b>4.</b> <input type="checkbox"/> Packaged Dental/Life/Disability Plan				Before today, were you covered under this employer's dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No								

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

Social Security Number	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
<b>Subscriber Primary Language (other than English)</b> <b>Primer Idioma del suscriptor (que no sea el Ingles)</b>		<b>Subscriber Disability</b>		
What is your primary Language? ¿Cuál es su primer idioma? _____		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	Coverage Election	Other Health Coverage	Other Dental Coverage	Prior Dental Coverage	Student Age 19 or Older	Primary Office ID Number (If applicable)	Current Patient	Dental Office ID Number (If applicable)	Current Patient
Employee 1.				/ /			<input type="checkbox"/> Yes <input type="checkbox"/> No	<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	N/A		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse 2.				/ /			<input type="checkbox"/> Yes <input type="checkbox"/> No	<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	N/A		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Child 3.				/ /			<input type="checkbox"/> Yes <input type="checkbox"/> No	<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		<input type="checkbox"/> Yes <input type="checkbox"/> No
Child 4.				/ /			<input type="checkbox"/> Yes <input type="checkbox"/> No	<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		<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 1. <input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02 <input type="checkbox"/> Hispanic or Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____	Child 3. <input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02 <input type="checkbox"/> Hispanic or Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____
Spouse 2. <input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02 <input type="checkbox"/> Hispanic or Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____	Child 4. <input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02 <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

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.

Social Security Number

E. Other Insurance (Continued)

PROOF OF PRIOR COVERAGE - IMPORTANT (Required)
Does anyone enrolling on this enrollment form have prior coverage?
Yes No If you answered "yes", provide applicant names, start and end dates of prior 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 if enrolling in other than an HMO plan. You may request a Certificate of Creditable Coverage from your prior carrier.

Proof of coverage must accompany this enrollment form for pre-existing condition credit if enrolling in other than an HMO plan.

F. Dependent Information

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

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.

1. Medical Coverage Declined for: Myself Spouse Dependents
2. Dental Coverage Declined for: Myself Spouse Dependents
Reason for Declining Coverage (If applicable, please attach front/back of your health coverage ID card.):
Covered by spouse's group coverage - Carrier Name and ID Number:
Enrolled in other Insurance Carrier Plans - Carrier Name and ID Number:
Spouse covered by employer's group medical coverage Spouse covered by employer's group dental coverage
Medicare Covered by TRICARE or CHAMPVA Other (Explain):

I acknowledge 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 other than an HMO plan, may not be covered for twelve months.

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

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.

Table with 7 rows of health questions and Yes/No columns. Questions include: Had cardiovascular disease or heart attack; Has any person to be covered had or been told they have an immune disorder, AIDS or AIDS-Related Complex; Have you or any dependents visited a health care professional for any illness; Have you or any dependent been advised in the last 12 months that hospitalization, surgery or treatment is needed; Is any female currently pregnant; If you are a male, are you expecting a child; Does anyone use tobacco products; Has any applicant taken any prescribed medications in the past 6 months.

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

Social Security Number

**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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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: \_\_\_\_\_

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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: \_\_\_\_\_

**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 and Aetna QPOS Plan: Aetna Health Inc., Corporate Health Insurance Company, and/or Aetna Life Insurance Company
  - Aetna PPO Plan: Aetna Life Insurance Company
  - Life, Accidental Death & Dismemberment, disability, dental and all other 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 application have been accepted and approved by Aetna. Even if this application is approved, I understand that Aetna cannot rescind my coverage based on my health, however, coverage can be rescinded or reevaluated, as of the effective date, for eligibility and rating purposes, due to my misrepresentation, fraudulent statements, or omission of information regarding my health.
 

**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, substance abuse and HIV/AIDS. 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 coverage and so long thereafter as allowed by law, which in no event shall be for more than twenty-four (24) months. 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. I understand that I may revoke this authorization by calling Member Services using the toll free number listed on my Member Identification Card. Upon receipt of my request, I will be sent a Revocation of Authorization form by Aetna to be completed and returned to Aetna. Aetna will accept a form developed by my employer or my hand-written request for revocation of authorization. However, the employer form or my request must include all of the data elements that are included in Aetna's standard revocation form.
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 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 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, 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. 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 subjects such person to criminal and civil penalties.

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 Oklahoma 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 24 hours per week for this employer at the regular place of business.

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