

**NOTE: 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.**



# 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"/> Change of coverage	<input type="checkbox"/> Employee Termination	COBRA/State Continuation for: <input type="checkbox"/> Employee <input type="checkbox"/> Dependent	
	<input type="checkbox"/> Rehire/Reinstatement	<input type="checkbox"/> Add Spouse/Domestic Partner/Dependent Child	<input type="checkbox"/> Remove Spouse/Domestic Partner/Dependent Child		
Date of Hire	<input type="checkbox"/> New Group Enrollment	<input type="checkbox"/> Name Change	<input type="checkbox"/> Cancel Coverage	Length of Continuation: <input type="checkbox"/> 18 <input type="checkbox"/> 36 <input type="checkbox"/> Other _____	
	<input type="checkbox"/> Late Enrollment	<input type="checkbox"/> Other _____		Original Qualifying Event Date _____	
<input type="checkbox"/> Other _____				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 <input type="checkbox"/> Packaged Dental/Life/Disability Plan					<b>2. Dental</b> - Check one. <b>Standard Plans</b> <input type="checkbox"/> Option 1 <input type="checkbox"/> Option 4 <input type="checkbox"/> Option 2 <input type="checkbox"/> Option 5 <input type="checkbox"/> Option 3: <input type="checkbox"/> Option 6 <input type="checkbox"/> DMO® or <input type="checkbox"/> PPO <input type="checkbox"/> Out-of-State PPO <b>Voluntary Plans</b> <input type="checkbox"/> Option V1 <input type="checkbox"/> Option V3 <input type="checkbox"/> Option V2 <input type="checkbox"/> Out-of-State PPO <input type="checkbox"/> DMO® or <input type="checkbox"/> PPO Before today, were you covered under this employer's dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No					<b>3. Life and Disability</b> <input type="checkbox"/> Basic Life/AD&D Ultra™ <input type="checkbox"/> Optional Dependent Life <input type="checkbox"/> Life & Disability Packaged Plan 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 _____
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"/> Full-Time <input type="checkbox"/> Part-Time	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single
Subscriber Primary Language (other than English) Primer Idioma del suscriptor (que no sea el Ingles)		Subscriber Disability	
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.**

**NOTE: Enter Domestic Partner ONLY if your employer has elected that coverage.**

(A)id (C)hange (R)emove	Name (Last, First, M.I.)	Sex M/F	Social Security Number	Birthdate (MM/DD/YYYY)	Incapacitated	Coverage Election	Other Health Coverage	Other Dental Coverage	Prior Dental Coverage	Student Age 19 or Older	Primary Office ID Number (if applicable)	Dental Office ID Number (if applicable)	Current Patient	Current Patient
Employee	1.				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life/Dis	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner (DP)	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	<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"/> 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	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child	5.				<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	<input type="checkbox"/> Yes <input type="checkbox"/> No

**D. Dependent Information**

Does any dependent listed in Section C live at another address? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, who and what address? _____	If any dependent's last name differs from yours, explain the circumstances. _____
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Social Security Number
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**E. 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.)

<b>1. Employee</b>	<input type="checkbox"/> White – 01	<input type="checkbox"/> African American or Black – 02	<input type="checkbox"/> Hispanic or Latin – 03	<input type="checkbox"/> Asian – 04	<input type="checkbox"/> Other – 05
<b>2. Spouse/DP</b>	<input type="checkbox"/> White – 01	<input type="checkbox"/> African American or Black – 02	<input type="checkbox"/> Hispanic or Latin – 03	<input type="checkbox"/> Asian – 04	<input type="checkbox"/> Other – 05
<b>3. Child</b>	<input type="checkbox"/> White – 01	<input type="checkbox"/> African American or Black – 02	<input type="checkbox"/> Hispanic or Latin – 03	<input type="checkbox"/> Asian – 04	<input type="checkbox"/> Other – 05
<b>4. Child</b>	<input type="checkbox"/> White – 01	<input type="checkbox"/> African American or Black – 02	<input type="checkbox"/> Hispanic or Latin – 03	<input type="checkbox"/> Asian – 04	<input type="checkbox"/> Other – 05
<b>5. Child</b>	<input type="checkbox"/> White – 01	<input type="checkbox"/> African American or Black – 02	<input type="checkbox"/> Hispanic or Latin – 03	<input type="checkbox"/> Asian – 04	<input type="checkbox"/> Other – 05

**F. 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/Domestic Partner employed?  Yes  No If Yes, provide name and address of spouse/domestic partner's employer.

**PROOF OF PRIOR COVERAGE – IMPORTANT** (Required)

Does anyone enrolling on this enrollment form have prior coverage?  Yes  No If Yes, provide the information requested in the table below.

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.

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

Name of Covered Individual	Carrier Name	Group Number	Start Date	Termination Date	Health	Dental
					<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	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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.**

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

<p>Please sign here <b>ONLY</b> if you are declining coverage for yourself or your dependent(s).</p> <p><b>X</b> Employee Signature</p>	<p>Date (Month/Day/Year)</p>
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**H. Health Questionnaire for Groups Enrolling 2 - 50 Eligible Employees** (and employees of groups enrolling for Life coverage greater than the Guaranteed Issue Level)

**Health History for Employees and your 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 enrollment form will be returned.
- Incomplete enrollment forms may delay the effective date of your coverage.

List all individuals enrolling for coverage.	Sex	Age	Height	Weight	Smoker	Currently Taking Prescription Medication(s)
Name					<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	<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
					<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

Continued on next page



Social Security Number

**Conditions of Enrollment** *(continued)*

3. I understand and agree that this Enrollment/Change 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/Change 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/domestic partner and competent adult dependents and I have obtained their consent to those terms. This authorization will remain valid for the term of the 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 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, 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 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/domestic partner, 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. 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.

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.

<b>Employee Signature</b> X	<b>Spouse/Domestic Partner Signature</b> X	<b>Employee E-mail Address (optional)</b>	<b>Date (Month/Day/Year)</b>
<b>Employer Signature</b> X			<b>Date (Month/Day/Year)</b>