



MEDICAL ENROLLMENT/CHANGE REQUEST FORM

TRAVEL HCP PLAN

<input type="checkbox"/> PLATINUM AETNA PPO PLAN \$20 Office Visit Copay <u>Coinsurance</u> 85% In-Network/60% Out-of-Network <u>Deductible</u> \$750 Individual/\$1,500 Family (in-network) Prescription - \$25 Generic/\$50 Brand Name	<input type="checkbox"/> BASE AETNA PPO PLAN \$25 Office Visit Copay <u>Coinsurance</u> 75% In-Network/50% Out-of-Network <u>Deductible</u> \$1,500 Individual/\$3,000 Family (in-network) Prescription - \$30 Generic/\$60 Brand Name
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TYPE OF ACTIVITY			
Enrollment Check One	Change Check all that apply	Remove or Terminate Check all that apply	Continuation of Coverage, i.e., COBRA Contact employer for available options
<input type="checkbox"/> New Enrollee <input type="checkbox"/> Rehire Effective Date ____/____/____ Date of Hire ____/____/____ Date of Rehire ____/____/____	Date of Event ____/____/____ Reason _____ <input type="checkbox"/> Add Spouse <input type="checkbox"/> Add Dependent Child <input type="checkbox"/> Name Change <input type="checkbox"/> Other Control Suffix/ Acct Plan _____	Effective Date ____/____/____ Reason _____ <input type="checkbox"/> Remove Spouse <input type="checkbox"/> Remove Dependent Child <input type="checkbox"/> Employee Withdrawal <input type="checkbox"/> Termination <input type="checkbox"/> Cancel Coverage	Coverage for: <input type="checkbox"/> Employee <input type="checkbox"/> Dependents Length of Continuation: <input type="checkbox"/> 18 <input type="checkbox"/> 36 <input type="checkbox"/> Other Explain: _____ Date of Loss of Coverage: ____/____/____ Date of Qualifying Event: ____/____/____

1 - EMPLOYEE INFORMATION - PLEASE PRINT CLEARLY

Employee Last Name: _____ First Name: _____ M.I. _____ Division Name: _____ Group # _____

Address: _____ City: _____ State: _____ Zip Code: _____ Job Title/Status: _____

Gender: Male Female Marital Status: Single Married Date of Birth: ____/____/____

Social Security#: _____ Date of Hire: ____/____/____ Fulltime Part-time Class: _____

Date Returned from Leave or Layoff: ____/____/____ Date Qualified under Cobra: ____/____/____

2- ELIGIBLE DEPENDENTS - LIST SPOUSE FIRST (IF YOU NEED MORE SPACE, ATTACH A SEPARATE SHEET OF PAPER.)

First Name, Middle Initial	Last Name (If different than employee's)	Relationship To Employee	Birth date	Sex	Social Security #	Fulltime student 19 or older? * Y or N
		Spouse				

*Complete the following for each child, age 19 or older, who attends an accredited school fulltime.

School Name _____ Term Begins ____/____/____ Expected Graduation Date ____/____/____

School Name _____ Term Begins ____/____/____ Expected Graduation Date ____/____/____



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3 - OTHER COVERAGE INFORMATION

Are you or any eligible family members currently covered by other group health insurance? Yes No

If you answered "Yes" above, place a check next to those covered by other insurance and complete the rest of the information requested in Section 3.

Myself My spouse My dependent children

Name of Insurance Carrier:

Name of Group:

To whom is the other coverage issued?

Spouse's Birth Date:

Myself My Spouse Other

____/____/____

4 - EMPLOYEE ELECTION AND SIGNATURE - ALWAYS REQUIRED

I hereby **apply** for coverage for:
(Check only those that apply.)

I hereby **decline** coverage for:
(Check only those that apply.)

Myself Myself and my dependents

Myself Myself and my dependents

I read and understand the back of this form and request the actions checked above. I authorize any physician, hospital, pharmacy, employer, insurer, or other party to allow Aetna or their representatives to view, or receive copies or details of any medical data they have about me or my dependents, including treatment for sexually transmitted disease, HIV-related testing and treatment, and drug, alcohol, and psychiatric treatment, as needed to determine our eligibility for benefits. I understand that this information cannot be disclosed without my authorization. A copy of this authorization is as valid as the original.

Employee's Signature _____ Date ____/____/____

IMPORTANT INFORMATION ABOUT THIS INSURANCE APPLICATION

PLEASE READ CAREFULLY. THIS INFORMATION REFERS TO THE "EMPLOYEE SIGNATURE" SECTION ON THIS FORM.

IF YOU ARE APPLYING FOR THE INSURANCE to which you are now entitled or may become entitled under the Group Policy issued to your employer by Aetna:

Your signature on this form affirms that you understand that the agreement will take effect only upon approval of your application. The agreement will be binding only if the statements you make to induce acceptance of this application are true and complete to the best of your knowledge. Your signature authorizes payroll deductions to pay for your portion (if any) of the premium when your coverage becomes effective.

If you or your dependents received medical care or treatment within the 90 days prior to your effective date for a disease or physical condition: care or advice for that condition may not be covered, or coverage may be limited, until you or the dependent has been covered by this plan for one year. This exclusion applies only to a disease or physical condition for which you or your dependent received medical care or advice within the 90 days prior to your effective date.

If you are declining coverage for yourself or your eligible dependents: Your signature on this form affirms that you understand that you are eligible for benefits under the Group Policy issued to your employer by Aetna. You understand the benefits offered through this Plan. You decline coverage for yourself or your eligible dependents (as you indicated above on this form) and waive all claims to benefits under the Plan. Further, you understand that if you request coverage for yourself or your dependents at a later date, you will not be offered coverage except during the annual open enrollment period, described below.

SPECIAL ENROLLMENT PERIOD - If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependents in this plan in the future, provided that you request enrollment within 30 days after your other coverage ends.

If you acquire a new dependent through marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth adoption, or placement for adoption.

As required by HIPAA (Health Insurance Portability and Accountability Act of 1996) this notice is to inform you that your Aetna Health Plan contains a preexisting condition exclusion period that extends for a period of 12 months.

You and/or your dependent(s) can reduce the length of the preexisting condition exclusion period by providing Aetna with a certificate showing prior creditable coverage.