

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.



Georgia Small Group Business (2 - 99 Eligible Employees) Employee Enrollment/Change Form

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 H.						
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/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							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 - Check one. <input type="checkbox"/> POS Open Access – Plan: _____ <input type="checkbox"/> MC Open Access – Plan: _____ <input type="checkbox"/> Indemnity – Plan: _____					2. Dental – To enroll, enter plan number and name below. Standard Plans: Plan Number: _____ Plan Name: _____ If Freedom-of-Choice, check: <input type="checkbox"/> DMO® or <input type="checkbox"/> PPO Voluntary Plans: Plan Number: _____ Plan Name: _____ If Freedom of Choice, check: <input type="checkbox"/> DMO® or <input type="checkbox"/> PPO Out-of-State PPO Plans: Plan Name: _____ Before today, were you covered under this employer's dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No					3. Life and Disability <input type="checkbox"/> Basic Life/AD&D Ultra® <input type="checkbox"/> Optional Dependent Life <input type="checkbox"/> Short Term Disability <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	Primary Language Spoken (Optional)
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
No. of Dependents Including Spouse _____				

C. 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. Some exceptions apply. Please refer to your plan documents or contact your benefits administrator.

(A)dd (C)hange (R)emove	Name (Last, First, M.I.)	Sex M/F	Social Security Number	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-Life only	Primary Office ID Number (if applicable)	Current Patient	Dental Office ID Number (if applicable)	Current Patient
	Employee 1.						Yes <input type="checkbox"/>	<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 <input type="checkbox"/>		Yes <input type="checkbox"/>
	Spouse 2.						<input type="checkbox"/>	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A		<input type="checkbox"/>		<input type="checkbox"/>
	Child 3.						<input type="checkbox"/>	<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"/>
	Child 4.						<input type="checkbox"/>	<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"/>

D. Other Insurance

Does anyone age 19 and over enrolling on this enrollment form have current or prior coverage? Yes No

Proof of coverage should accompany this enrollment form for pre-existing condition credit and if an employee is waiving coverage. Acceptable forms of proof are:

- Certificate of Creditable Coverage from prior carrier, or
- Copy of ID card or most recent payroll stub showing medical coverage deduction, or
- Copy of most recent medical premium bill from prior carrier.

Failure to provide Proof of Prior Coverage may subject you or a family member (age 19 and over) 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. NOTE: If your Plan contains a pre-existing conditions provision, the pre-existing conditions exclusion and limitation will not apply to a person under 19 years of age.

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

E. Medicare Information

Name of Person	Medicare Part A	Medicare Part B	Medicare Part D	Over Age 65	Disability	End-Stage Renal Disease Effective Date
	<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	

F. Dependent Information

List any dependent in Section C living at another address.	Name:	Reason:	Address:
If any dependent's last name differs from yours, explain.	Name:	Reason:	

FOR DEPENDENT LIFE: If age 19 and over and a full-time student, provide the following:

Child Name	Name School Name	Expected Graduation Date	Number of Credit Hours

G. 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 <input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02 1. <input type="checkbox"/> Hispanic or Latino – 03 <input type="checkbox"/> Asian – 04 <input type="checkbox"/> Other – 05 _____	Child <input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02 3. <input type="checkbox"/> Hispanic or Latino – 03 <input type="checkbox"/> Asian – 04 <input type="checkbox"/> Other – 05 _____
Spouse <input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02 2. <input type="checkbox"/> Hispanic or Latino – 03 <input type="checkbox"/> Asian – 04 <input type="checkbox"/> Other – 05 _____	Child <input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02 4. <input type="checkbox"/> Hispanic or Latino – 03 <input type="checkbox"/> Asian – 04 <input type="checkbox"/> Other – 05 _____

H. Declination/Waiver of Coverage - Check all that apply.

I understand I am eligible to apply for this coverage through my employer; however, I am waiving coverage as noted below.

<input type="checkbox"/> Employee	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	Reason for declining coverage (If applicable attach front/back of your health ID card): <input type="checkbox"/> Covered by spouse's group coverage - Carrier Name and ID number: _____ <input type="checkbox"/> Enrolled in other insurance - Carrier Name and ID number: _____ <input type="checkbox"/> Spouse covered by employer's group coverage <input type="checkbox"/> Medicare <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> Other _____
<input type="checkbox"/> Spouse	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	
<input type="checkbox"/> Child(ren)	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	

I certify 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 this plan, may not be covered for twelve months. **NOTE:** If your Plan contains a pre-existing conditions provision, the pre-existing conditions exclusion and limitation will not apply to a person under 19 years of age.

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

Employee Signature

I. Health Questionnaire for Groups Enrolling 2 - 9 Eligible Employees (or 2-99 if enrolling for Life above the Guaranteed Issue Amount)

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 36 months, 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, 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/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 gland, urinary system, male or female organs, infertility, menstrual dysfunction or sexually transmitted disease (except AIDS/ARC)?.....	<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 by a physician, or diagnosed, treated, or tested positive for 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"/> Insulin dependent <input type="checkbox"/> Non-insulin dependent	<input type="checkbox"/>	<input type="checkbox"/>
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 on next page.	<input type="checkbox"/>	<input type="checkbox"/>

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS ABOVE YOU MUST COMPLETE SECTION K ON THE FOLLOWING PAGE.

Disclosure Acknowledgment (Continued)

2. Physicians are paid either a discounted fee for service in accordance with a specific fee schedule or a predetermined set amount per member per month (capitation).
3. Laboratory services are provided through a capitation arrangement (a per member per month flat fee).
4. Other ancillary services including home health, skilled nursing, and hospice are paid on a contracted fee schedule with per diems or per visit amounts, or through a capitated per member per month flat fee.

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"):
 - In-network portion of Aetna POS plans: Aetna Health Inc.
 - Out-of-network portion of Aetna POS plans: Aetna Health Insurance Company
 - Life, Accidental Death & Dismemberment, disability, dental (except DMO[®]) and all other coverages: Aetna Life Insurance Company. DMO[®] dental coverage is provided by Aetna Health Inc.
2. I understand and agree that my employer's application will determine coverage and that there is no coverage unless and until both this enrollment form and the employer application have been accepted by Aetna. Even if this enrollment form is accepted, any intentional and material misstatements or omissions may result in future claims being denied and my coverage under the policy being rescinded or reevaluated, as of the effective date, for eligibility and rating purposes.

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. For Dependent Life, dependents are eligible from 14 days of age up to their 19th birthday, or up to their 23rd birthday, if a full-time student.
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"), including pharmacies or pharmacy database benefit managers to give Aetna or its agent information concerning the medical history, prescription utilization 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 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. 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, 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 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.

Misrepresentation

7. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any person who knowingly and with intent to defraud any insurance company or other person files an enrollment form 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 **Georgia** Small Group Business (2-99 Eligible Employees) Employee Enrollment/Change Form. I understand that, in the event I fail to sign this form within 31 days of my eligibility date 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 25 hours per week for this employer at the regular place of business.

I have read and understand the information provided in the Disclosure section of this form.

<i>Employee Signature</i>	<i>Spouse Signature (Optional - required only if enrolling)</i>	<i>Employee E-mail Address (optional)</i>	<i>Date (Month/Day/Year)</i>
X	X		