Dental Enrollment/Change Request

Aetna Life Insurance Company *

Employer Group Information: (To Be Completed by Employer)	Employer Name - Full Name of Business or Organization	Control	Suffix	Account	Plan Number
	Employer Address (Street, City, State, ZIP Code) - Primary Location of Business or Organization				

A. Type of Activity - Employee Completes Sections A - E. ***Please Print Clearly.***

Instructions: *Refer to the instructions on the back before completing this form. 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.*

Enrollment - *Check one.*
- ☐ New Enrollee/Subscriber — Effective Date / / — Date of Hire / /
- ☐ Rehire/Reinstatement — Date of Rehire/Reinstatement / /

Change - *Check all that apply.*
- ☐ Add Spouse
- ☐ Add Dependent Child
- ☐ Name Change
- ☐ Other
- ☐ Control/Suffix/Acct/Plan

Date of Event / / — Reason

Remove or Terminate - *Check all that apply.*
- ☐ Remove Spouse
- ☐ Remove Dependent Child
- ☐ Employee Withdrawal/ Termination
- ☐ Cancel Coverage

Effective Date / / — Reason

Continuation of Coverage, i.e., COBRA, State - ***Not all options are available. Contact Employer for available options.***

Coverage For: ☐ Employee ☐ Dependents

Length of Continuation (months): ☐ 18 ☐ 36 ☐ Other _____

☐ 29 - Attach disability determination from the Social Security Admin.

Date of Loss of Coverage / / — Date of Qualifying Event / /

B. Employee Information

Social Security Number	Last Name, First Name, M.I.	Primary Language Spoken

Employee Home Address: Number, Street, Apt; City, State; ZIP Code

Telephone Numbers: Home ( ) Work ( )

Employee Status: ☐ Active ☐ Retired

C. Plan Options - **Your selection must be offered by your employer.**

Check One:

- ☐ Indemnity Dental
- ☐ DentalFund/HealthFund
- ☐ Dental PPO
- ☐ Dental EPP
- ☐ DMO®/Advantage/Basic
- ☐ FOC/Indemnity
- ☐ FOC/PPO
- ☐ FOC/DMO

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. * ***Provide details for "Yes" responses below.*** ☐ **Check this box if you are refusing coverage for your dependents.**

(A)dd (C)hange (R)emove	Name (First, Middle Initial, Last) (Explain difference in last names in Special Remarks.)	Relation Code	Sex M F	Birthdate MM DD YYYY	Social Security Number (If dependent has no SSN, write "None")	Late Entrant	Prior Insur. Plan	Other Dental Coverage	Currently Covered by Medicare	Handi-capped	Student	Primary Dentist Office ID Number	Current Patient
		Self	☐☐	/ /		Yes ☐	Yes * ☐	Yes * ☐	Yes * ☐	Yes N/A	Yes N/A		Yes ☐
			☐☐	/ /		☐	☐	☐	☐	☐	☐		☐
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			☐☐	/ /		☐	☐	☐	☐	☐	☐		☐

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.)

Code	Other

Using the KEY below, please identify the Race/Ethnicity code for each individual.

KEY:
- **01** - White
- **02** - African American or Black
- **03** - Hispanic or Latino
- **04** - Asian
- **05** - Other (Provide race/ethnicity in "Other" column at left)

1. If "Yes" to **Prior Insurance Plan** above, provide effective dates, name & policy number of insurance carrier, dental plan or other source and your **Member Identification Number**.

2. If "Yes" to **Other Dental Coverage** and/or **Currently Covered by Medicare** above, provide effective dates, name & policy number of insurance carrier, dental plan or other source and your **Member Identification Number**.

3. Does any dependent listed above live at a different address than the employee? If "Yes," who and what address? ☐ Yes ☐ No

Special Remarks

E. Employee Signature ☐ *By checking this box you agree to use Aetna Navigator, Aetna's member self-service website, for all future printed materials.*

I certify that all information supplied in this form is true and complete to the best of my knowledge and/or belief. I have read and agree to the Conditions of Enrollment on the reverse side of this Enrollment/Change Request form. I understand that in the event I fail to sign this form within 31 days after the above transaction request or that 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.

Employee Signature - *Required*
X

Date / / — E-Mail Address

Instructions

Employer - Complete the **Employer Group Information** at the top of the form.

Employee - Complete Sections A - E.

Section A -Type of Activity:

- Check box(es) indicating reason(s) for submitting this Enrollment/Change Request.
- Provide Effective Date(s) and Date of Event(s) where requested.

Section B - Employee Information: Complete **all** information in order for your Enrollment/Change Request to be processed.

Section C - Plan Options: Select only an option offered by your employer.

Section D - Individuals Covered:

- Add/Change/Remove - Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependent(s), if applicable. Indicate Relationship Code, Sex, Birthdate, and Social Security Number for each individual listed.
  - Relationship Code - Use **ONLY**: H=Husband, W=Wife, S=Son, D=Daughter, Y=Sponsored Male, X=Sponsored Female. **If the dependent is NOT your spouse or a biological or legally adopted child, please indicate relationship to employee in Special Remarks.**
- **Late Entrant** - If you are **not** enrolling within your employer's eligible enrollment period, check "Yes".
- If you or your dependent(s) were covered under your employer's or other **Prior Insurance Plan**, check the "Yes" box and provide beginning and ending effective dates, name and policy number of insurance carrier, dental plan or other source and your **Member Identification Number** in the space provided in Number 1.
- If you or your dependent(s) have **Other Dental Coverage** and/or are **Currently Covered by Medicare**, check the "Yes" box(es) and provide beginning and ending effective dates, name and policy number of insurance carrier, dental plan or other source and your **Member Identification Number** in the space provided in Number 2.
- If a dependent is Handicapped and financially dependent, check "Yes" and provide proof of handicapped status from the attending physician.
- If a dependent is a Student, check "Yes". Refer to your Summary Coverage for plan definitions. Aetna may request that you provide proof from the educational institution.
- Primary Dentist Office ID Number - Locate the office ID number for the primary dentist from the appropriate provider directory or from "DocFind®", Aetna's online provider directory at "www.aetna.com".
- If you are a current patient, please check the "Yes" box under Current Patient. A current patient is a patient who has been treated by the dentist for routine care within the last 12 months.
- *Optional* - Using the KEY provided, please enter the Race/Ethnicity code for each individual. If your Race/Ethnicity is "Other," print the Race/Ethnicity for each individual in the space provided.

Section E - Employee Signature:

- Complete this section for all new enrollments or coverage changes.
- Employee must sign and date the Enrollment/Change Request in order for it to be processed.
- By checking the box on the reverse side you agree to use Aetna Navigator, Aetna's member self-service website, for all future printed materials.

Conditions of Enrollment

Applicant Acknowledgments and Agreements

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 underwritten or administered by the following entities (collectively referred to as "Aetna"):
   - Aetna Dental PPO, Dental EPP, Aetna HealthFund/Aetna DentalFund and Aetna Indemnity Dental: Aetna Life Insurance Company
   - Aetna DMO, Advantage and Basic: Aetna Health Inc. (AZ)
2. I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments as required for coverage.
3. I understand and agree that this Enrollment/Change Request 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 Aetna or its agent information concerning the medical history, services or treatment provided to anyone listed on this Enrollment/Change Request 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. I understand that this authorization is provided under state law and that it is not 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 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. Authorizations signed for the purpose of collecting information in connection with this application for an insurance policy, a policy reinstatement or a request for a change in policy benefits shall remain valid for thirty (30) months from the date it is signed. Authorizations signed for the purpose of collecting information in connection with a claim for benefits shall remain valid for the term of this coverage or for so long as allowed by law. The information, as well as other personal or privileged information, subsequently collected by the insurance institution or agent may in certain circumstances, be disclosed to third parties without authorization. A right of access and correction exists with respect to all personal information collected. Further disclosures required by Arizona law will be furnished to the policyholder upon request. Personal information may be collected from persons other than the individual or individuals proposed for coverage.
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 (including all participating primary care dentists) 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.