

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 pages 2 and 3 are not visible.



# Ohio (51+ Eligible Employees) Employee Enrollment/Change Request

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"/> New Group Enrollment	<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"/> Late Enrollment <input type="checkbox"/> Other _____			

**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"/> OAHMO: _____ <input type="checkbox"/> OAMC: _____ <input type="checkbox"/> PPO: _____ <input type="checkbox"/> H S A / H R A: _____				<b>2. Dental</b> - Check one. <input type="checkbox"/> DMO®: _____ <input type="checkbox"/> FOC: _____ <input type="checkbox"/> PPO: _____ <input type="checkbox"/> Voluntary: _____				<b>3. Life and Disability</b> <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 <hr/> Beneficiary Designation - <b>Full Name</b> (First, Middle, Last) _____ <hr/> Beneficiary Social Security Number _____ Relationship to Employee _____				

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

Member Aetna ID Number (if available)	Last Name, First Name, M.I.	Job Title	Home Telephone	Primary Language Spoken (Optional)
Home Address		Apt. No.	City, State	
Work Address		City, State		ZIP Code
Work Telephone				
Salary (required) \$ _____		<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"/> 1099 <input type="checkbox"/> Seasonal <input type="checkbox"/> Full-time <input type="checkbox"/> Retired <input type="checkbox"/> Temporary	No. of Dependents Including Spouse _____

**NOTE FOR MEDICAL COVERAGE:** While the Federal Patient Protection and Affordable Care Act mandates coverage of dependent children up to age 26 and the State of Ohio mandates coverage of dependent children meeting certain criteria up to age 28, your plan may allow coverage beyond these ages. Some exceptions apply.

**C. Individuals Covered - List individuals for whom you are enrolling or adding/changing/removing coverage. Insert additional sheets if necessary.**

Name (Last, First, M.I.)	Sex M/F	Social Security Number	Relationship	Birthdate MM / DD / YYYY	Height (ft, in)	Weight (lbs)	Status	Coverage Election	PCP Provider ID#
Employee 1.			Self				<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life/Dis	
Spouse 2.			<input type="checkbox"/> Spouse <input type="checkbox"/> Other _____				<input type="checkbox"/> Different last name	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	
Child 3.			<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____				<input type="checkbox"/> Different last name <input type="checkbox"/> Lives at another address <input type="checkbox"/> Full-time Student (Life Only) <input type="checkbox"/> Disabled	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	
Child 4.			<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____				<input type="checkbox"/> Different last name <input type="checkbox"/> Lives at another address <input type="checkbox"/> Full-time Student (Life Only) <input type="checkbox"/> Disabled	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	

**D. Dependent Information**

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

**E. Other Insurance**

Does anyone over age 19 enrolling on this enrollment form have current or prior medical and/or dental 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:  
 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 over age 19 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

**F. Medicare Information**

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

**G. Declination/Waiver of Coverage - To be completed if medical and/or dental coverage is declined or refused by an eligible and/or their eligible family members.**

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

<input type="checkbox"/> Employee	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Life	<input type="checkbox"/> Disability	<b>Reason for declining coverage (If applicable attach front/back of your health ID card):</b> <input type="checkbox"/> Covered by spouse's group coverage - Carrier Name and ID number: _____  <input type="checkbox"/> Enrolled in other insurance (check applicable box): <input type="checkbox"/> Medicare <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> Military <input type="checkbox"/> Individual <input type="checkbox"/> Retiree <input type="checkbox"/> Other _____ Carrier Name and ID number: _____ <input type="checkbox"/> Spouse covered by employer's group insurance <input type="checkbox"/> Do Not Want
<input type="checkbox"/> Spouse	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Life		
<input type="checkbox"/> Child(ren)	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Life		

I represent I have been given the right to apply for this coverage, however, I am electing not to enroll. 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 medical plan, may not be covered for **ninety** days. 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 or dependent(s). Date (Month/Day/Year)  
**X** Employee Signature

**H. 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 _____

**I. 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 enrollment form will be returned.
- Incomplete enrollment forms may delay the effective date of your coverage.

1. Within the last 5 years has anyone applying for coverage consulted, received treatment, by a doctor, psychiatrist, psychologist, or other practitioner or been diagnosed with any of the following conditions or disorders? (Check all that apply.)	Yes	No
a. <input type="checkbox"/> AIDS or HIV b. <input type="checkbox"/> Diabetes c. <input type="checkbox"/> Infertility d. <input type="checkbox"/> Endocrine/Metabolic e. <input type="checkbox"/> Pancreas f. <input type="checkbox"/> Liver/Hepatitis g. <input type="checkbox"/> Immune System h. <input type="checkbox"/> Blood Disorder i. <input type="checkbox"/> Epilepsy/Seizure j. <input type="checkbox"/> Heart k. <input type="checkbox"/> Paralysis/Paresis l. <input type="checkbox"/> Tumor/Cyst/Growth m. <input type="checkbox"/> Systemic or Discoid Lupus n. <input type="checkbox"/> Lung or Respiratory o. <input type="checkbox"/> Alcohol or Drug Use p. <input type="checkbox"/> Kidney/Bladder/Urinary q. <input type="checkbox"/> Circulatory/Vascular r. <input type="checkbox"/> Digestive/Stomach/Intestinal s. <input type="checkbox"/> Central Nervous System t. <input type="checkbox"/> Pituitary/Adrenal/Growth Disorder u. <input type="checkbox"/> Birth Defects v. <input type="checkbox"/> Arthritis/Bone/Joint/Muscle/Prosthetic Device w. <input type="checkbox"/> Mental/Nervous/Emotional/Eating Disorder x. <input type="checkbox"/> Stroke/Brain/Neurological y. <input type="checkbox"/> Transplant: <input type="checkbox"/> Recommended <input type="checkbox"/> Pending <input type="checkbox"/> Complete z. <input type="checkbox"/> Advised to have surgery or course of treatment not yet determined aa. <input type="checkbox"/> Cancer: Type _____ Stage _____ <input type="checkbox"/> Surgery <input type="checkbox"/> Chemo <input type="checkbox"/> Radiation bb. <input type="checkbox"/> Using: <input type="checkbox"/> Crutches <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair cc. <input type="checkbox"/> Other _____		
2. Is any female pregnant? If so, provide due date _____ Check applicable boxes: <input type="checkbox"/> C section planned <input type="checkbox"/> Multiple births expected (# _____) Complications: <input type="checkbox"/> Past or <input type="checkbox"/> Present		
3. Has anyone applying for coverage incurred medical expenses in excess of \$5,000 in the past 24 months? .....	<input type="checkbox"/>	<input type="checkbox"/>
4. Has anyone applying for coverage been prescribed medications in the past 12 months? .....	<input type="checkbox"/>	<input type="checkbox"/>
5. Does anyone applying for coverage have a known condition that requires ongoing treatment? .....	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you or spouse use tobacco products? If so, check the applicable boxes. .... <input type="checkbox"/> Employee: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Pipe <input type="checkbox"/> Cigars <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Spouse: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Pipe <input type="checkbox"/> Cigars <input type="checkbox"/> Chewing Tobacco	<input type="checkbox"/>	<input type="checkbox"/>

continued on next page

**I. Health Questionnaire** *(continued)*

**Provide details below to any boxes checked above. (If additional space is needed, attach a separate sheet and be sure to sign and date the sheet.)**

Question Number	Name of Individual	Condition/Diagnosis	Date of Onset	Date Treatment Ended	Names of Prescription Medication(s)	Dosage	Still Taking Medication
							<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
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							<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

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

**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 Managed Choice Open Access: Aetna Life Insurance Company
  - Aetna HMO Plan: Aetna Health Inc. and Aetna Health Insurance Company
  - Life, Accidental Death & Dismemberment, disability, and all other health coverages: Aetna Life Insurance Company
2. I understand and agree that my employer's application will determine coverage for the group and that there is no coverage unless and until the group has been accepted and approved by Aetna subject to any state requirements.
3. **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.
4. I understand and agree that this Enrollment/Change Request may be transmitted to Aetna 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 Request, 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. Authorizations signed for the purpose of collecting information in connection with an application for an insurance policy, a policy reinstatement or a request for a change in policy benefits shall remain valid for (30) months from the date 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. 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.

**Notice: Neither the brokers that handled this insurance nor the insurers, that have underwritten this insurance, will disclose Non-Public Personal Information concerning the buyer, to non-affiliates of the brokers or insurers, except as permitted by law.**

*continued on next page*

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

5. 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. Any direct conflict between this form and the plan documents will be resolved according to the terms which are most favorable to the member.
6. I understand and agree that, with the exception of Aetna Rx Home Delivery<sup>®</sup>, 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.
7. I understand and agree that, with certain exceptions described in the plan documents, DMO<sup>®</sup> 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.
8. Pre-existing conditions, when enrolled in this medical plan, may not be covered for **ninety** days. 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.

**Misrepresentation**

9. Attention Ohio Residents: 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 is guilty of insurance fraud.

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 **Ohio** (51+ Eligible Employees) Employee Enrollment/Change Request. I understand that, in the event I fail to sign this form within 31 days of my eligibility date 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 30 hours per week for this employer at the regular place of business.

<i>Employee Signature</i>	<i>Employee E-mail Address (optional)</i>	<i>Date (Month/Day/Year)</i>
<b>X</b>		