

Enrollment/Change Request Instructions

To Enroll: Complete all sections, except Section 8

To Make Changes: *For all changes* - complete Sections 2, 3, 9 and 10. Depending on the Type of Activity box(es) selected, complete the corresponding applicable sections.
A Withdrawal/Termination also requires completion of Section 8.

Section 1 Check one Plan Option box, indicate Plan Option Name (where applicable) and check one Primary Co-pay and/or Individual Deductible Amount (if applicable).

Section 2 Complete **all** information in order for your application to be processed.

Section 3 Check box(es) indicating reason(s) for submitting form. Provide Effective Date/Date of Event and Reason (where requested).

Section 4 Print your full name along with the name(s) of your dependent(s), if applicable. Indicate Sex, Date of Birth, and Social Security Number for each individual listed. If a dependent is a full-time college student, you **must** attach a current course schedule or letter from the school confirming full-time student status (12 or more credits). To indicate whether you are Adding or Removing self and/or dependents, check the appropriate Add or Remove boxes.

Section 5 From the appropriate provider directory, locate the office number for the primary care physician and/or dentist (if applicable). Indicate office number selection(s) on form. Check the change block **only** if you are a current member and are changing providers.

Sections 6 & 7 Complete these sections for all new enrollments or coverage changes (if applicable).

Section 8 Complete this section only if Withdrawing/Terminating from the plan.

Sections 9 & 10 Complete these sections for all new enrollments or coverage changes. Employee and Employer must sign and date the application in order for it to be processed.

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. Enrollment of yourself and of the listed dependents into the plan is effective on acceptance by Aetna U.S. Healthcare.
2. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. Your employer is hereby authorized to withhold payments from your wages as appropriate.
3. As a condition of coverage, you understand and agree that (with the exception of emergency procedures and certain direct access services as defined in the plan documents) all services, in order to be covered by Aetna U.S. Healthcare, 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*.

* *Some services may require prior authorization from Aetna U.S. Healthcare.*

4. You agree to make copayments, as provided for in your plan documents, directly to providers of health care.
5. Aetna U.S. Healthcare (including its affiliates and authorized agents, collectively "Aetna U.S. Healthcare") and participating network providers require access to member medical information for a number of purposes, including claims payment and fraud prevention; preventive health, early detection and disease management programs; coordination of patient care; quality improvement/management/assessment; utilization review and management; fulfilling state and federal requirements; HEDIS and similar data collection and reporting; accreditation by the National Committee for Quality Assurance and other accreditation organizations; and statistical research. Accordingly, you authorize the sharing of member medical information about yourself and your listed dependents between Aetna U.S. Healthcare and any hospital, physician, or other health care provider or health delivery system as Aetna U.S. Healthcare and such participating providers may require. 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. Please be assured that it is Aetna U.S. Healthcare's policy to protect the confidentiality of your confidential medical information to the full extent required by the law. I know that I, or an individual entitled to act on my behalf, am entitled to receive a copy of this authorization upon request and agree that a photocopy is as valid as the original.
6. 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 HMO plan.
7. You authorize the substitution of generic pharmaceuticals for the brand-name products for prescriptions filled under any pharmacy benefit rider.
8. You understand that this coverage will remain in effect until your employer's next open-enrollment period regardless of the continued availability of a particular primary care physician or other health care provider.
9. You acknowledge that Aetna U.S. Healthcare's participating providers, including all participating primary care physicians, are independent contractors and are neither agents nor employees of Aetna U.S. Healthcare.

Your enrollment in Aetna U.S. Healthcare and accessing of your benefits signifies your agreement to these conditions, which are subject to change.



Enrollment/Change Request

Aetna U.S. Healthcare®

Please read instructions on reverse side before completing this form.

P.O. Box 24023
Fresno, CA 93779

Group Name _____

Group Number (HMO, USAccess and QPOS Only) _____

Aetna U.S. Healthcare ID No. _____

1. Plan Option (Check One) *Print clearly.*

HMO USAccess™ QPOS® Primary Co-pay: \$0 \$2 \$5 \$10 \$15 Other _____

Individual Deductible Amount: *(Complete for QPOS Plans Only)*
 \$100 \$200 \$300 \$400 \$500 \$750 \$1,000
 Other _____

(Please Indicate Plan Name)

2. Employee Information

Last Name, First Name, M.I.		Social Security Number	
Home Address		Apartment Number	
City, State	Zip Code	Home Telephone ()	
Employer Name		Work Telephone ()	
Work Address	Zip Code	Date of Hire	

3. Type of Activity

New Subscriber Effective Date _____ Change Plan To _____
 Date of Event _____

Add/Remove Spouse* Reason _____ Date of Event _____
 Add/Change Primary Office*
 Add/Change Primary Dentist*

Add/Remove a Dependent Child* Reason _____ Date of Event _____
 Withdrawal/Termination (Complete Section 8 Below)

Name Change From _____ To _____ Date of Event _____

* **Complete Sections 4 & 5 Below**

4.	No.	Add	Remove	Last Name, First Name, M.I.	Sex		Date of Birth MM DD YYYY	Social Security No.
					M	F		
Employee	a.	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	/ /	
Spouse	b.	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	/ /	
Children	c.	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	/ /	
* Attach sheet to list additional children * Attach proof if full-time college student	d.	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	/ /	
	e.	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	/ /	
	f.	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	/ /	

5.	Change	Primary Office No.	Dentist Office No. <small>(if applicable)</small>
a.	<input type="checkbox"/>		
b.	<input type="checkbox"/>		
c.	<input type="checkbox"/>		
d.	<input type="checkbox"/>		
e.	<input type="checkbox"/>		
f.	<input type="checkbox"/>		

6. Other Insurance

Is your Spouse Employed? Yes No
 If Yes, please give name and address of spouse's employer. _____

Does your spouse have health insurance? Yes No
 If Yes, please give name and policy number of insurance carrier or other HMO. _____
 If Yes, who is covered by this policy?
 Yourself Yourself/Spouse Spouse Only Entire Family

7. Dependent Information

Do any of the dependents listed in Section 4 live at another address? Yes No

If Yes, who and at what address? _____

Explain the circumstances. _____

If any dependent's last name is different from yours, explain the circumstances. _____

8. Withdrawal From Plan

No Longer in Group Date of Withdrawal _____ Individual Conversion - Bill me at Home (prescription and dental benefits are not convertible) I Decline Nongroup Coverage

Note: For COBRA information - See your employer.

If you have any questions concerning the benefits and services that are provided by or excluded under this Agreement, please contact a Member Services representative before signing this form.

9. Employee Signature

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the reverse side of the employee copy of this application.

Subscriber _____ Date _____ E-mail Address _____

Employee copy may be used as a temporary ID card for 30 days from the effective date if authorized by employer. Coverage must be verified with Aetna U.S. Healthcare prior to visiting a specialist or admission to a hospital.

10. Employer Verification

Signature _____	Title _____	Date _____
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