



Florida Small Group Business (2 - 50 Eligible Employees) Employee Enrollment/Change Form

Life, Accidental Death & Dismemberment, Disability, Aetna Managed Choice, and Aetna PPO plans are underwritten by Aetna Life Insurance Company. Aetna HMO and Aetna POS plans are underwritten by Aetna Health Inc. Dental plans are provided or administered by Aetna Life Insurance Company.

Member Aetna ID Number (if available)

Employer Name		INSTRUCTIONS: 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. If waiving coverage, please complete Sections B and G.					
Effective Date	<input type="checkbox"/> New Hire <input type="checkbox"/> Late Enrollment	<input type="checkbox"/> Change of Coverage	<input type="checkbox"/> Employee Termination	COBRA/State Continuation for:			
Date of Hire	<input type="checkbox"/> Rehire/Reinstatement	<input type="checkbox"/> Add Spouse/Dependent Child	<input type="checkbox"/> Remove Spouse/Dependent Child	<input type="checkbox"/> Employee <input type="checkbox"/> Dependent			
	<input type="checkbox"/> New Group Enrollment	<input type="checkbox"/> Name Change	<input type="checkbox"/> Cancel Coverage	Length of Continuation:			
	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____		<input type="checkbox"/> 18 <input type="checkbox"/> 36 <input type="checkbox"/> Other _____			
				Original Qualifying Event Date _____			
				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.				2. Dental - Check one.				3. Life and Disability				
<input type="checkbox"/> Aetna HMO Open Access - Plan Option _____				<input type="checkbox"/> Aetna Dental™ Plan - Plan Option _____				<input type="checkbox"/> Basic Life / AD&D Ultra™				
<input type="checkbox"/> Aetna POS Open Access - Plan Option _____				<input type="checkbox"/> Freedom of Choice: <input type="checkbox"/> DMO or <input type="checkbox"/> PPO				<input type="checkbox"/> Optional Dependent Life				
<input type="checkbox"/> Aetna Managed Choice Open Access - Plan Option _____				<input type="checkbox"/> Out-of-State PPO - Plan Option _____				<input type="checkbox"/> Short Term Disability				
<input type="checkbox"/> Aetna PPO - Plan Option _____				Before today, were you covered under this employer's dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Life & Disability Packaged Plan				
<input type="checkbox"/> Out-of-State PPO - Plan Option _____								Beneficiary Designation - Full Name (First, Middle, Last)				
								Beneficiary Social Security No. 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 (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"/> Full-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.

(Add/Change/Remove)	Name (Last, First, M.I.)	Sex M/F	Social Security No.	Birthdate MM / DD / YYYY	Height (ft. in)	Weight (lbs)	Incapacitated Yes N/A	Coverage Election				Student Age 19 or Older	Primary Office ID Number (If applicable)	Current Patient	Dental Office ID Number (If applicable)	Current Patient
								Medical	Dental	Life	Other Health Coverage					
Employee	1.			/ /				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	<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
Spouse	2.			/ /			N/A	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	N/A		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Child	3.			/ /				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	<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
Child	4.			/ /				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	<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

D. Dependent Information

Does any dependent listed in Section C live at another address? If Yes, who and what address? <input type="checkbox"/> Yes <input type="checkbox"/> No	If any dependent's last name differs from yours, explain the circumstances.
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E. Other Insurance

Does anyone enrolling on this enrollment form have prior coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
If you are age 65 or older, are you eligible and enrolled for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, provide the effective date: ____ / ____ / ____ (month/day/year) and check the applicable boxes: <input type="checkbox"/> Part A <input type="checkbox"/> Part B
Proof of coverage must 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 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.

Name of Covered Individual	Carrier Name	Group Number	Start Date	Termination Date	Health	Dental
					<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

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.

F. 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 _____

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

1. Medical Coverage Declined for: <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents 2. Dental Coverage Declined for: <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents I acknowledge I have been given the right to apply for this coverage; however, I am waiving coverage as noted above.	Reason for Declining Coverage (If applicable, please attach front/back of your health coverage ID card.): <input type="checkbox"/> Covered by spouse's group coverage - Carrier Name and ID Number: _____ <input type="checkbox"/> Enrolled in other Insurance Carrier Plans - Carrier Name and ID Number: _____ <input type="checkbox"/> Spouse covered by employer's group medical coverage <input type="checkbox"/> Spouse covered by employer's group dental coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Covered by TRICARE or CHAMPVA <input type="checkbox"/> Other (Explain): _____
I acknowledge 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.	
Please sign here ONLY if you are declining coverage for yourself and/or dependent(s).	
X Employee Signature	Date (Month / Day / Year)

H. Health Questionnaire for Groups Enrolling 2 - 9 Eligible Employees (or 2 - 50 if enrolling for life above the Guarantee Issue amount) and All New Enrollees for Existing Groups with 2-50 Eligible Employees. All new business groups do not need to complete this section if they are eligible to complete the Group Medical 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 application will be returned.
- Incomplete applications may delay the effective date of your coverage.

In the past five (5) years, 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 glands, urinary systems, 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 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"/>
10. Has any person been diagnosed with diabetes? If yes, list date of diagnosis: ____ / ____ / ____ (month/day/year)	<input type="checkbox"/>	<input type="checkbox"/>
Insulin dependent? _____ Non-insulin dependent? _____		
11. 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"/>
12. Has any applicant taken any prescribed medications in the past 12 months? If yes, list below.	<input type="checkbox"/>	<input type="checkbox"/>
13. Has any applicant had an abnormal physical exam or been advised to undergo further testing, surgery or treatment?	<input type="checkbox"/>	<input type="checkbox"/>
14. Has any applicant been a patient in a hospital, clinic, surgical center, sanatorium or medical facility as an outpatient or inpatient (excluding childbirth)?	<input type="checkbox"/>	<input type="checkbox"/>
15. Does anyone named on this application use tobacco products, including cigarette, pipe, cigar, or chewing tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, check applicable boxes: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse		
16. Has any applicant had any medical condition not listed on this application?	<input type="checkbox"/>	<input type="checkbox"/>
Has any person listed on this enrollment form been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	<input type="checkbox"/>	<input type="checkbox"/>

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS ABOVE (EXCEPT LAST QUESTION), YOU MUST COMPLETE SECTION I ON THE FOLLOWING PAGE.

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

I. Health Questionnaire - Details for "Yes" Responses in Section H.

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS IN SECTION H (EXCEPT LAST QUESTION), YOU MUST COMPLETE THE FOLLOWING.

Please provide us with FULL DETAILS for each "Yes" answer to any condition(s) checked in Section H. **In addition**, please give details below of last doctor visit and/or physical examination for **ALL** family members listed regardless of the date or reason. *(Insert additional sheets if necessary.)*

Question Number:	Name of Person Treated:					
Name of Illness/Condition:						
Date of Onset: Month	Year	Date Treatment Ended: Month	Year	Still under Treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Treatment Given:						
Medication:						
Date Prescribed:	Month	Year	Month	Year	Month	Year
Dosage:						
Question Number:	Name of Person Treated:					
Name of Illness/Condition:						
Date of Onset: Month	Year	Date Treatment Ended: Month	Year	Still under Treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Treatment Given:						
Medication:						
Date Prescribed:	Month	Year	Month	Year	Month	Year
Dosage:						
Question Number:	Name of Person Treated:					
Name of Illness/Condition:						
Date of Onset: Month	Year	Date Treatment Ended: Month	Year	Still under Treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Treatment Given:						
Medication:						
Date Prescribed:	Month	Year	Month	Year	Month	Year
Dosage:						
Question Number:	Name of Person Treated:					
Name of Illness/Condition:						
Date of Onset: Month	Year	Date Treatment Ended: Month	Year	Still under Treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Treatment Given:						
Medication:						
Date Prescribed:	Month	Year	Month	Year	Month	Year
Dosage:						

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 HMO plans: Aetna Health Inc.
 - Aetna POS plans: Aetna Health Inc.
 - Life, Accidental Death & Dismemberment, disability, dental and all other health coverages: Aetna Life Insurance Company
2. I understand and agree that my employer's application will determine coverage and that there is no coverage unless and until both the eligible employee enrollment form and employer applications have been accepted and approved by Aetna. **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.
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"), including pharmacies or pharmacy database benefit managers to give to Aetna or its agent information concerning the medical history, prescription utilization history, services or treatment provided to anyone listed on this Enrollment/Change Request form, including those involving mental health and substance abuse. 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 for 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.
7. I understand and agree that, as described in the plan documents and when enrolled for medical coverage, any pre-existing conditions for my spouse, dependents or myself may not be covered for 12 months.

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 Florida Small Group Business (2 - 50 Eligible Employees) Employee Enrollment/Change Form.

I understand that, in the event I fail to sign this form within 31 days after the above transaction request 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.

Misrepresentation: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

<i>Employee Signature</i>	<i>Spouse Signature (Optional - Required only if enrolling)</i>	<i>Employee E-mail Address (optional)</i>	<i>Date (Mo./Day/ Yr.)</i>
X	X		