Aetna Medical Enrollment/Change Request

To Be Completed By Employer		Control	Suffix	Account	Plan Number
		Plan Description			

☐ New Enrollment ☐ Open Enrollment ☐ Mid-Year Qualifying Event

Employee Information

Effective Date	Date of Hire	Plan Options
Date of Birth	Social Security Number	Check One: ☐ POS ☐ HDHP
Last Name, First Name, MI		

Home Address Apt No City State Zip

Home Phone	Work Phone	Gender	Marital Status
		Male _____ Female _____	Single _____ Married _____

Dependent Information

Add/Remove	Last Name, First Name, MI	Date of Birth	Gender	Social Security Number
	Spouse		Male ___ Female ___	
	Child		Male ___ Female ___	
	Child		Male ___ Female ___	
	Child		Male ___ Female ___	
	Child		Male ___ Female ___	
	Child		Male ___ Female ___	

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.	Employee Signature	Date

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:

- I acknowledge that by enrolling in an Aetna plan coverage is underwritten or administered by Aetna Life Insurance Company (referred to as "Aetna").
- I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments as required for coverage.
- 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 30 months from the date I sign it or in the case of the information described above being collected in connection with a medical claim, this authorization will be valid for the term of the coverage. In the case of a life claim, this authorization will remain valid for the duration of the claim. I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original.

- The plan documents will determine the rights and responsibilities of member(s) and will govern in the event that conflict with any benefits comparison, summary or other description of the plan.
- 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.

Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive 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 commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Staunton City/Staunton City Schools

Waiver of Medical Coverage Form

Effective 01/01/2020 – 12/31/2020

Please Complete the following if you are waiving medical coverage for yourself and/or your spouse and dependents:

Employee Name: _____ _____ _____

Last First MI

Date of Birth: _____

If waiving coverage for Medical, please complete the following information:

☐ My preference not to have coverage

☐ Coverage under my spouse – Name of Carrier _____

☐ Other Coverage – Name of Carrier _____

This other coverage is:

☐ Individual ☐ COBRA ☐ Medicare ☐ TRICARE (formally CHAMPUS)

☐ Medicaid ☐ Employer – Sponsored Group Plan

Special Enrollment Notices and Certification

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. I am declining enrollment as indicated above. I understand that I am declining enrollment for myself or my eligible dependents (including my spouse) because of other health insurance or group health plan coverage. I may be able to enroll my eligible dependents and myself in this plan if I lose, or my eligible dependents lose, eligibility for that other coverage (or if the employer stops contributing towards my eligible dependents' or me other coverage).

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends (or after the employer stops contributing toward the other coverage). If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period.

In addition, I understand that if I have newly eligible dependent because of marriage, birth, adoption, or placement for adoption, I may be able to enroll my eligible dependent and myself. However, I must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
In addition, I understand that I must request enrollment if my dependent or myself loses eligibility under a Medicaid plan or CHIP, or request termination if my dependent or myself becomes eligible for a premium assistance subsidy under Medicaid or CHIP within 60 days.

I understand that in order to request enrollment or obtain more information, I should contact my group administrator.

_____ _____

Signature of Employee Date of Signature