



Colorado Small Group Business (1 - 50 Eligible Employees) Employee Enrollment/Change Form

Member Aetna ID Number (if available)

Employer Name _____ **INSTRUCTIONS:** 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. **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: <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 _____ Reason _____
Date of Hire	<input type="checkbox"/> Rehire/Reinstatement	<input type="checkbox"/> Other _____	<input type="checkbox"/> Add Spouse/Dependent Child	<input type="checkbox"/> Remove Spouse/Dependent Child	
	<input type="checkbox"/> New Group Enrollment		<input type="checkbox"/> Name Change	<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.
1. Medical - Check one. <input type="checkbox"/> Aetna Managed Choice Plan _____ <input type="checkbox"/> Basic Preferred Provider Plan <input type="checkbox"/> Basic Indemnity <input type="checkbox"/> Standard Preferred Provider Plan <input type="checkbox"/> Standard Indemnity					2. Dental - Check one. Standard Plans: <input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2: <input type="checkbox"/> DMO or <input type="checkbox"/> PPO <input type="checkbox"/> Option 3 <input type="checkbox"/> Option 4 <input type="checkbox"/> Option 5 <input type="checkbox"/> Option 6 <input type="checkbox"/> Out-of-State Indemnity Before today, were you covered under this employer's dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No					3. Life and Disability <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 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"/> 1099 <input type="checkbox"/> Seasonal <input type="checkbox"/> Full-time <input type="checkbox"/> Retired <input type="checkbox"/> Temporary
					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.

Name (Last, First, M.I.)	Sex M/F	Social Security Number	Birthdate MM / DD / YYYY	Relationship	Height (ft, in)	Weight (lbs)	Status	Coverage Election	PCP Provider ID#
Employee 1.							<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	
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 (+19) <input type="checkbox"/> Disabled (+19)	<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 (+19) <input type="checkbox"/> Disabled (+19)	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	
Child 5.				<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 (+19) <input type="checkbox"/> Disabled (+19)	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	
Child 6.				<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 (+19) <input type="checkbox"/> Disabled (+19)	<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 _____
Why? _____ What is their address? _____

If any dependents last name differs from your, explain? Name _____
Reason _____

If age 19+ and a full-time student, provide the following:

Child Name	School Name	Expected Graduation Date	Number of Credit Hours

After completion, sign, remove tape from inside pages, fold closed and press to seal, and submit to your employer.

E. Other Insurance

Does anyone enrolling on this enrollment form have current or prior coverage? Yes No

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
					<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 - Check all that apply.

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

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

I certify 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.
For groups enrolling 1 employee: Pre-existing conditions, when enrolled in this plan, may not be covered for **twelve** months*.
For groups enrolling 2 to 50 employees: Pre-existing conditions, when enrolled in this plan, may not be covered for **six** months*.
 *Pre-existing condition exclusion applies when there has been separation of coverage for more than 90 days.

Please sign here ONLY if you are declining coverage for yourself or dependent(s).

Employee Signature _____ **Date (Month / Day / Year)** _____

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 <input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02 1. <input type="checkbox"/> Hispanic or Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____	Child <input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02 4. <input type="checkbox"/> Hispanic or Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____
Spouse <input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02 2. <input type="checkbox"/> Hispanic or Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____	Child <input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02 5. <input type="checkbox"/> Hispanic or Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____
Child <input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02 3. <input type="checkbox"/> Hispanic or Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____	Child <input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02 6. <input type="checkbox"/> Hispanic or Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____

I. Health Questionnaire for Groups Enrolling 1- 50 Employees

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.

In the past five (5) years, has any person listed on the enrollment form 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"/>

continued on next page

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS ABOVE, YOU MUST COMPLETE SECTION J ON THE FOLLOWING PAGE.
 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 PPO Plan, Aetna Traditional Choice Plan, Basic PPO, Standard PPO, Basic Indemnity and Standard Indemnity: Aetna Life Insurance Company
 - Life, Accidental Death & Dismemberment, disability, dental and all other 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 and employer applications have been accepted and approved by Aetna. Even if this enrollment form is approved, any misstatements or omissions may result in future claims being denied and the policy or my coverage under the policy being rescinded or reevaluated, as of the effective date, for eligibility and rating purposes.

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 form 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, services or treatment provided to anyone listed on this enrollment 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 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, 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. **For groups enrolling 1 employee:** Pre-existing conditions, when enrolled in this plan, may not be covered for **twelve** months.
For groups enrolling 2 to 50 employees: Pre-existing conditions, when enrolled in this plan, may not be covered for **six** months.

COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO SMALL EMPLOYERS OF 2 - 50 EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP. BUSINESS GROUPS OF ONE CANNOT BE REJECTED UNDER A BASIC OR STANDARD HEALTH BENEFIT PLAN DURING OPEN ENROLLMENT PERIODS AS SPECIFIED BY LAW.

Misrepresentation

8. It is unlawful to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Attention Colorado Residents: An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.

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 Colorado Small Group Business (1 - 50 Eligible Employees) Employee Enrollment/Change Form. I understand that, in the event I fail to sign this form within 31 days of my eligibility date 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 24 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 (Mo./Day/ Yr.)</i>
X		