Florida Employee Enrollment/Change Form (For Groups of 100 or Fewer Employees)

Life, Accidental Death & Personal Loss Coverage (AD&D Ultra®), Disability, Aetna Vision℠ Preferred, 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. For Vision coverage, certain claims administration services are provided by First American Administrators, Inc. and certain network administration services are provided through EyeMed Vision Care, LLC ("EyeMed").

INSTRUCTIONS: Please be thorough and complete all sections that apply. You are solely responsible for its accuracy and completeness. If you are waiving coverage, complete sections A and F

Member Aetna ID Number (if available)

Company Name

Effective Date / Date of Hire / Benefit Waiting Period* ☐ Class 1 ☐ Class 2 * only required when your employer has 2 benefit waiting periods	☐ New Hire ☐ Rehire/Reinstatement* ☐ Late Enrollment ☐ Waiver ☐ Open Enrollment *Does not apply to Supplemental or Dependent Life Insurance	☐ Add Spouse ☐ Add Domestic Partner ☐ Add Dependent Child ☐ Change of Coverage ☐ Name Change	☐ Employee Termination Date: _____ ☐ Remove Spouse ☐ Remove Domestic Partner ☐ Remove Dependent Child ☐ Cancel Coverage ☐ Other _____

☐ COBRA ☐ Continuation for: ☐ Employee ☐ Dependent Length of Continuation: ☐ 18 ☐ 36 ☐ Other _____

Qualifying Event _____ Original Qualifying Event Date _____ Loss of Coverage Date _____

A. Employee Information

Social Security Number	Last Name, First Name, M.I.		Job Title
Home Address (PO Box not acceptable)	Apt. No.	City, State	ZIP Code
Work Address (PO Box not acceptable)		City, State	ZIP Code
Home Telephone ( ) -	Work Telephone ( ) -	Primary Language Spoken (Optional)	Number of Dependents including Spouse enrolling for coverage

Salary (if electing life coverage) $ _____	☐ Hourly ☐ Weekly ☐ Monthly	No. of Hours Worked Per Week	Check One ☐ Full-Time ☐ Part-Time ☐ 1099 ☐ Retired ☐ Seasonal ☐ Temporary ☐ COBRA ☐ Union

B. Coverage Selection – *Please print clearly, using black ink. (Shaded sections for Employer/Aetna use only)*

Control/Group No.	Suffix	Account	Plan No.	Class Code

1. Medical:
   - ☐ Aetna HNOnly (HMO OA) – Plan Option: _____
   - ☐ Aetna HNOption (POS OA) – Plan Option: _____
   - ☐ Aetna ValuePick – Plan Option: _____
   - ☐ Aetna Savings Plus (HMO GK) – Plan Option: _____
   - ☐ Aetna Managed Choice Open Access – Plan Option: _____
   - ☐ Other – Plan Option: _____

Control/Group No.	Suffix	Account	Plan No.	Class Code

2. Dental - Check one (if applicable):

Standard Plans:
- ☐ Aetna Dental® Plan – Plan Option: _____
- ☐ FOC: ☐ Managed Dental *or* ☐ PPO

Voluntary Plans:
- ☐ Aetna Dental® Plan – Plan Option: _____
- ☐ FOC: ☐ Managed Dental *or* ☐ PPO

Before today, were you covered under this employer's dental plan? ☐ Yes ☐ No

Creditable coverage is allowed for new members enrolling in voluntary takeover groups. New hires please see below if applicable:

New Hire selecting a Voluntary Plan and your Aetna plan is a takeover group: Were you covered for 12 months under a dental plan within the last 90 days that included both Preventive and Basic coverage? Discount dental and preventive only plans do not apply. ☐ Yes ☐ No

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B. Coverage Selection *(continued)*

Control/Group No.	Suffix	Account	Plan No.

3. Vision (if applicable)

Aetna Vision Preferred ☐ Yes ☐ No *Check applicable box.*

Control/Group No.	Suffix	Account	Plan No.

4. Life and Disability ☐ Yes ☐ No

Life/AD&D Ultra® (for groups with 2-9 employees) *Check applicable boxes*

☐ Employee Basic Life/AD&D Ultra®

Life/AD&D Ultra® (for groups with 10-100 employees) *Check applicable boxes*

☐ Employee ☐ Basic Life/AD&D Ultra® ☐ Supplemental Life/AD&D Ultra®

☐ Spouse ☐ Optional Spouse Life/AD&D Ultra®

☐ Child ☐ Optional Child Life/AD&D Ultra®

DESIGNATION OF BENEFICIARY – Carefully review Additional Conditions and Instructions for Designation of Beneficiary on Page 6.

Life Products require the employee to designate a beneficiary for benefits. A beneficiary is the person or entity who will receive the benefit payment. A primary beneficiary will be the first to receive the benefit. A contingent beneficiary will only receive the benefit payment if the primary beneficiary dies or is no longer available. The employee is automatically the primary beneficiary for dependent life and accidental death and personal loss coverage (AD&D Ultra®) benefits.

Beneficiary For:	Full Name(s) or Entity (Trust or Estate)	Date of Birth	Social Security Number / Tax ID Number	Address (Number, Street, Apt. No., City, State, ZIP Code)	Phone	Relationship to Employee	% of Benefit (must equal 100%)
Basic Life/ AD&D Ultra® Primary							
Basic Life/ AD&D Ultra® Contingent							
Supplemental Life/AD&D Ultra® Primary							
Supplemental Life/AD&D Ultra® Contingent							

SPOUSAL CONSENT FOR COMMUNITY PROPERTY STATES ONLY – See Additional Conditions and Instructions for Designation of Beneficiary Section on Page 6.

Please note that an Employee is under no obligation to complete the Spousal Consent section on this form.

I am aware that my spouse, the Employee named above, has designated someone other than me to be the beneficiary of group life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.

Spouse Signature _____ Date _____

Disability - (*Coverage for Employee only) Check applicable boxes.*

Short Term Disability (for groups with 2-100 employees) ☐ Yes ☐ No

Long Term Disability (for groups with 10-100 employees) ☐ Yes ☐ No

Life and Disability Packaged Plan (for groups with 2-50 employees) ☐ Yes ☐ No

C. Individuals Covered - *List individuals for whom you are enrolling or adding/changing/removing coverage. Insert additional sheets if necessary.* NOTE FOR MEDICAL COVERAGE: While the Federal Patient Protection and Affordable Care Act mandates coverage of dependent children up to age 26, your plan may allow coverage beyond age 26. Some exceptions apply. Please refer to your plan documents or contact your benefits administrator.

1	(A)dd (C)hange ___ (R)emove	Employee Name (Last, First, M.I.)			Sex (M/F)	Birthdate (MM/DD/YYYY) / /
Coverage Election ☐ Medical ☐ Dental ☐ Life/AD&D Ultra® ☐ Vision ☐ STD ☐ LTD ☐ Life & Disability Packaged Plan		If choosing HMO, Primary Office ID #	Current Patient Yes ☐	If choosing DMO, Primary Office ID #	Current Patient Yes ☐	

2	(A)dd (C)hange ___ (R)emove	Name (Last, First, M.I.) ☐ Spouse ☐ Domestic Partner		Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /
Coverage Election ☐ Medical ☐ Dental ☐ Life/AD&D Ultra® ☐ Vision		If choosing HMO, Primary Office ID #	Current Patient Yes ☐	If choosing DMO, Primary Office ID #	Current Patient Yes ☐	

3	(A)dd (C)hange ___ (R)emove	Name (Last, First, M.I.) ☐ Child ☐ Stepchild ☐ Other		Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /
Coverage Election ☐ Medical ☐ Dental ☐ Life/AD&D Ultra® ☐ Vision	If choosing HMO, Primary Office ID #	Current Patient Yes ☐	If choosing DMO, Primary Office ID #	Current Patient Yes ☐	Incapacitated ☐ Yes ☐ No	

4	(A)dd (C)hange ___ (R)emove	Name (Last, First, M.I.) ☐ Child ☐ Stepchild ☐ Other		Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /
Coverage Election ☐ Medical ☐ Dental ☐ Life/AD&D Ultra® ☐ Vision	If choosing HMO, Primary Office ID #	Current Patient Yes ☐	If choosing DMO, Primary Office ID #	Current Patient Yes ☐	Incapacitated ☐ Yes ☐ No	

5	(A)dd (C)hange ___ (R)emove	Name (Last, First, M.I.) ☐ Child ☐ Stepchild ☐ Other		Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /
Coverage Election ☐ Medical ☐ Dental ☐ Life/AD&D Ultra® ☐ Vision	If choosing HMO, Primary Office ID #	Current Patient Yes ☐	If choosing DMO, Primary Office ID #	Current Patient Yes ☐	Incapacitated ☐ Yes ☐ No	

6	(A)dd (C)hange ___ (R)emove	Name (Last, First, M.I.) ☐ Child ☐ Stepchild ☐ Other		Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /
Coverage Election ☐ Medical ☐ Dental ☐ Life/AD&D Ultra® ☐ Vision	If choosing HMO, Primary Office ID #	Current Patient Yes ☐	If choosing DMO, Primary Office ID #	Current Patient Yes ☐	Incapacitated ☐ Yes ☐ No	

D. Dependent Information

List any dependent in Section C living at another address.	
Name	Address

E. Coordination of Benefits

Will you have other health insurance at the same time as this coverage? ☐ Yes ☐ No			
Name of Person	Carrier Name	Name of Person	Carrier Name

F. 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/AD&D Ultra® ☐ Vision
- ☐ STD ☐ LTD
- ☐ Life & Disability Packaged Plan

☐ Spouse/Domestic Partner:
- ☐ Medical ☐ Dental
- ☐ Life/AD&D Ultra® ☐ Vision

☐ Child(ren):
- ☐ Medical ☐ Dental
- ☐ Life/AD&D Ultra® ☐ Vision

Reason for declining coverage

- ☐ Spouse/Domestic Partner group coverage
- ☐ Parental group coverage
- ☐ Medicare
- ☐ Medicaid
- ☐ Retiree coverage
- ☐ Another group plan provided by my employer
- ☐ COBRA coverage
- ☐ Insurance through another job
- ☐ TRICARE Military coverage
- ☐ Individual coverage – On Exchange
- ☐ Individual coverage – Off Exchange
- ☐ I have no other coverage
- ☐ Other _____

I certify 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 I and/or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage.

Please sign here ONLY if you are declining coverage for yourself and/or dependent(s).	*Date (Month/Day/Year)*
X Employee Signature	

Conditions of Enrollment

On behalf of myself and the dependents listed:

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 & Personal Loss Coverage (AD&D Ultra®), disability, dental, Vision and all other health coverages: Aetna Life Insurance Company. For Vision coverage, certain claims adjudication and other administrative services are provided by First American Administrators, Inc. (an affiliate of EyeMed Vision Care, LLC) and/or its affiliates.
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 coverage: I understand that the effective date of insurance for myself or for any of my dependents is subject to my being active 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. For Dependent Life, dependent children are eligible from birth up to their 26th birthday.
   For disability coverage: I understand that the effective date of my insurance is subject to my being active at work on that date. 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.

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Conditions of Enrollment *(continued)*

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 twenty-four (24) months. 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. I may revoke my authorization to disclose nonpublic personal health information at any time. I can make this revocation by completing and returning to Aetna a Revocation of Authorization form that will be sent to me by Aetna upon my request. Aetna also will accept a form developed by my employer or my hand-written request for revocation of authorization. However, the employer form or my request must include all the data elements that are included in Aetna's standard revocation form. This authorization is voluntary. However, I understand that if I refuse to sign this authorization form, my ability to enroll in the medical plans described above may be affected. I have the right to revoke this authorization in writing to Aetna at any time except to the extent that my information has already been used or disclosed in reliance on this authorization. However, because this information is essential to the administration of the plans, I understand that my revocation of this authorization may result in cancellation of my enrollment in the medical plans described above.
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 Managed Dental 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. To the best of my knowledge and belief, I represent that all information supplied in this form is true and complete. On behalf of myself and the eligible persons listed herein, I acknowledge that I have read and understand this form in its entirety.

I represent that all information supplied in this form is true and complete. I have read and agree to the Conditions of Enrollment and Fraud Statement on this Florida 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 eligibility 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. I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments as required for coverage.

If you wish to receive documents electronically, please refer to Aetna Navigator® at http://www.aetna.com/individuals-families/aetna-navigator.html.

Fraud Statement: 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.

Please sign here ONLY if you are enrolling in coverage for yourself and/or dependent(s). *Employee Signature* X	*Employee E-mail Address*	*Date (Month/Day/Year)*

Additional Conditions and Instructions for Designation of Beneficiary

Conditions for Designation of Beneficiary

- Please note: The Group Contract grants the member the authority to designate a beneficiary. A beneficiary designated by someone other than the member (i.e., attorney-in-fact, Power of Attorney, guardian, custodian, etc.) may be barred under the Group Contract, by the Power of Attorney executed by the member and/or by state law. The member should execute the beneficiary designation section of this form whenever possible to ensure the designation is deemed valid.
- Unless otherwise expressly provided in the Designation of Beneficiary section of this form, if any named beneficiary predeceases me, the life proceeds shall be payable equally to the remaining named beneficiary or beneficiaries. If no named beneficiary survives me, any sum becoming payable under said Group Policy(ies) by reason of my death shall be payable as prescribed in said Group Policy(ies).
- If this Designation of Beneficiary provides for payment to a trustee under a trust agreement, Aetna Life Insurance Company shall not be obliged to inquire into the terms of the trust agreement and shall not be chargeable with knowledge of the terms thereof. Payment to and receipt by the trustee shall fully discharge all liability of said Insurance Company to the extent of such payment.
- If you live in one of the following community property states – Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin – your spouse may have a legal claim for a portion of the life insurance benefit under state law. If you name someone other than your spouse as beneficiary, payment of the death benefit may be delayed until your spouse's claim is resolved.

Instructions for Designation of Beneficiary

If these instructions do not answer all your questions, please contact your plan sponsor for assistance.

Please use only black ink to complete this form.

- If you make a mistake in completing this form, line out the erroneous information, add the correct information and initial the correction. The printed material on this form should not be deleted or altered in any way.
- In all cases, the relationship of the beneficiary, the beneficiary's Social Security Number, address and phone number should be included with the beneficiary designations.
- Dollars and cents should not be specified.
- If a minor child is named beneficiary, the child will not receive the benefits until age of majority.
- If a trustee is named beneficiary, show the exact name of the trust, date of the trust agreement, and the name and address of the trustee. For example, The John J. Smith Revocable Life Insurance Trust, dated January 1, 1994. John Smith, Trustee, 123 Apple Lane, Hartford, CT 06006.