Aetna Enrollment/Change Request

Aetna U.S. Healthcare Dental Plan Inc. **

Check One: ☐ Indemnity Dental ☐ PPO Dental ☐ DMO® ☐ FOC/Indemnity ☐ FOC/PPO ☐ FOC/DMO

See Instructions on the back of the front page.

A. Transaction Information — EFFECTIVE DATE (MM/DD/YR)

1. Enrollment (Check One)

☐ New Enrollee
Hire Date ___/___/___ (MM DD YR)

☐ Rehired/Reinstatement
Date ___/___/___ (MM DD YR)

☐ Return to Work
Date ___/___/___ (MM DD YR)

2. Change

From ___-___-___ To ___-___-___

☐ Social Security Number
☐ Control/Suffix/Account
☐ Stop Continuation of Dental Coverage (i.e., COBRA)
☐ Other

3. Termination

☐ Terminating Employment - Reason
☐ Cancelling Coverage - Reason
☐ Continue Employee Dental Coverage (i.e., COBRA)
☐ Continue Dependent Dental Coverage (i.e., COBRA)

B. Employer Information

1. Employer Name - Full Name of Business or Organization	2. Control No.	Suffix	Account	3. Plan Number	4. SFO
AGMA HEALTH FUND		138			

5. Employer Address (Street, City, State, ZIP Code) - Primary Location of Business or Organization	6. Claim Office Code	7. Customer Code (Optional)	8. Network ID
1430 BROADWAY, Ste. 1203, NEW YORK, NY 10018			

C. Employee Information - Please Print All Information

1. Employee Social Security Number	2. Employee Name (Last, First, Middle Initial)	3. Employee Home Address
--		Number, Street, Apt

4. Employee Status	5. Sex	6. Home Telephone Number	7. Work Telephone Number	City	State	ZIP Code
☐ Active ☐ Retired		( ) -	( ) -			

8. Employee Primary Language	9. Employee Disability
What is your primary language?	Do you have a disability which affects your ability to communicate or read? ☐ Yes ☐ No If Yes, please indicate the nature of your disability:

D. Individuals Covered (List individuals for whom you are electing/changing coverage.)

☐ **Check this box if you are refusing coverage for your dependents.** * Additional information required. See Instruction page.

(A)dd/New (C)hange (R)emove	Relation. Code	Name (First, Middle Initial, Last) (Explain difference in last names in Special Remarks)	Social Security Number (If dependent has no SSN, write "None")	Birthdate MM / DD / YYYY	Dependent Address (If different than employee)	Late Entrant	Prior Insur. Plan	Other Dental Coverage	Currently Covered by Medicare	Handi-capped	Student Age 19 or Older	Primary Care Dentist ID # / Primary Care Dentist Name	Prev. Seen
						Yes	Yes*	Yes*	Yes	Yes*	Yes*		Yes
	Self		--	/ /	Not Applicable	☐	☐	☐	☐	N/A	N/A	ID # / Name	☐
			--	/ /		☐	☐	☐	☐	☐	☐	ID # / Name	☐
			--	/ /		☐	☐	☐	☐	☐	☐	ID # / Name	☐
			--	/ /		☐	☐	☐	☐	☐	☐	ID # / Name	☐
			--	/ /		☐	☐	☐	☐	☐	☐	ID # / Name	☐

Special Remarks

E. Acknowledgments - Signatures Required

Employee's E-mail Address:

I have read and agree to the terms of the authorization on the back of this Enrollment/Change Request form. I understand that, in the event I fail to sign this form within 31 days after the above transaction request or that 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.

Employee Signature X _____ Date _____ **Employer Signature** X _____ Date