Aetna US Healthcare

# Enrollment/Change Request

## Aetna Life Insurance Company

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

**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/Acct (B.2.) ___ / ___
- ☐ Stop Continuation of Health Coverage (i.e., COBRA)
- ☐ Other ___

**3. Termination**

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

*Check One:* ☐ Elect Choice® EPO ☐ HMO ☐ Managed Choice® POS ☐ Traditional Choice® ☐ Open Choice® PPO ☐ Other ___

**B. Employer Information**

| 1. Employer Name - Full Name of Business or Organization | 2. Control No. | Suffix | Account | 3. Plan Number | 4. Group Number (HMO Only) | 5. SFO |
|---|---|---|---|---|---|---|
| Agma Health Fund | 724290 | | | | | 138 |

| 6. Employer Address (Street, City, State, ZIP Code) - Primary Location of Business or Organization | 7. Claim Office Code | 8. Customer Code (Optional) | 9. 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. Beneficiary Designation - **Full Beneficiary Name** (First, Middle, Last) If more than one beneficiary, use Special Remarks. | Social Security Number of Beneficiary | Relationship to Employee | 9. Earnings |
|---|---|---|---|
| | - - | | ☐ Annually $ ___ ☐ Weekly $ ___ ☐ Insurance Amount $ ___ ☐ Supplemental Life $ ___ ☐ AD&D Amount $ ___ |

**D. Individuals Covered** (List individuals for whom you are electing/changing coverage.) ☐ Check this box if you are refusing coverage for your dependents.

| (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) | Prior Insur. Plan | Other Health Coverage | Currently Covered by Medicare | Handi-capped | Student Age 19 or Older | Primary Care Provider ID # / Primary Care Provider Name | Prev. Seen |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | 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 ___