

NOTE: Before you return this form to your employer, you may wish to tape or staple the form so that health information is not visible. This will help keep your health information private.



Nevada Employee Enrollment/Change Form (51-100 employees)

Aetna VisionSM Preferred plans, Aetna Open Access[®] Managed Choice (OAMC) plans and Aetna Indemnity plans are underwritten by Aetna Life Insurance Company. Aetna Whole Health (AWH) Las Vegas HMO plans and Aetna HNOption plans are underwritten by Aetna Health Inc. and Aetna Health Insurance Company. Dental plans are underwritten 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: You must complete this enrollment form in full. If you do not, we will return it to you, and that can delay its processing. You alone are responsible for its accuracy and completeness. **If you are declining coverage, you must complete Section G.** Please use only black ink to complete this form.

Group number
Aetna member ID number (if available)

Company name: _____			
Effective date	<input type="checkbox"/> New hire	<input type="checkbox"/> Add spouse	<input type="checkbox"/> Employee termination date: _____
	<input type="checkbox"/> Rehire / reinstatement	<input type="checkbox"/> Add domestic partner	<input type="checkbox"/> Remove spouse
Date of hire	<input type="checkbox"/> New group enrollment	<input type="checkbox"/> Add dependent child	<input type="checkbox"/> Remove domestic partner
	<input type="checkbox"/> Late enrollment	<input type="checkbox"/> Change of coverage	<input type="checkbox"/> Remove dependent child
	<input type="checkbox"/> Waiver	<input type="checkbox"/> Name change	<input type="checkbox"/> Cancel coverage
	<input type="checkbox"/> Open enrollment		<input type="checkbox"/> Other _____
	<input type="checkbox"/> Loss of coverage		
<input type="checkbox"/> COBRA for: <input type="checkbox"/> Employee <input type="checkbox"/> Dependent Length of continuation: <input type="checkbox"/> 18 months <input type="checkbox"/> 36 months <input type="checkbox"/> Other _____ Qualifying event _____ Original qualifying event date _____ Loss of coverage date _____			

A. Employee information – You must complete this section.

Social Security number	Last name, first name, middle initial		Job title
Home address	Apt. number	City, state	ZIP code
Work address	City, state		ZIP code
Home telephone () -	Work telephone () -	Primary language spoken (optional)	Number of dependents, including spouse or domestic partner, enrolling for medical coverage
Salary (if enrolling for life or disability coverage) \$ _____	<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	Number of hours worked a week	Check one: <input type="checkbox"/> Full time <input type="checkbox"/> 1099 <input type="checkbox"/> Seasonal <input type="checkbox"/> COBRA <input type="checkbox"/> Part time <input type="checkbox"/> Retiree <input type="checkbox"/> Temporary <input type="checkbox"/> Union

B. Coverage selection – Please print clearly. (Top boxes for employer and Aetna-use only.)

Control/Group number	Suffix	Account	Plan number	Class code
1. Medical <input type="checkbox"/> Yes <input type="checkbox"/> No <i>To enroll, check one and enter the plan option elected following the plan type below.</i> <input type="checkbox"/> Open Access[®] Managed Choice (OAMC) - Plan option _____ <input type="checkbox"/> Aetna Whole Health (AWH) Las Vegas HMO – Plan option _____ <input type="checkbox"/> Aetna HNOption – Plan option _____ <input type="checkbox"/> Indemnity (only available if PPO networks are not available) – Plan option _____				

B. Coverage selection (Continued)

Control/Group number	Suffix	Account	Plan number
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2. Dental Yes No *To enroll, enter the plan number and name below.*

Non-voluntary plans – Plan number _____ Plan name _____

Voluntary plans – Plan number _____ Plan name _____

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

Control/Group number	Suffix	Account	Plan number
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3. Vision

Aetna VisionSM Preferred Yes No

C. Individuals covered – List individuals for whom you are enrolling or adding, changing or removing coverage. Add more sheets if needed.

NOTE: Enter domestic partner ONLY if your employer has elected that coverage.

NOTE FOR MEDICAL COVERAGE: While the Affordable Care Act mandates coverage of dependent children up to age 26, your plan may allow coverage beyond age 26. Please refer to your plan documents or contact your benefits administrator.

1	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Employee name (Last, first, middle initial) _____	Sex (M/F) _____
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Birthdate (MM/DD/YYYY) / /	Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally separated	Choosing coverage for: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
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Primary care physician (PCP) provider ID number _____	Current patient <input type="checkbox"/> Yes	Dental provider office ID number _____	Current patient <input type="checkbox"/> Yes
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2	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Name (Last, first, middle, initial) <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner	Sex (M/F) _____	Social Security number _____
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Birthdate (MM/DD/YYYY) / /	Choosing coverage for: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
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PCP provider ID number _____	Current patient <input type="checkbox"/> Yes	Dental provider office ID number _____	Current patient <input type="checkbox"/> Yes
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3	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Name (Last, first, middle initial) <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____	Sex (M/F) _____	Social Security number _____
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Birthdate (MM/DD/YYYY) / /	Incapacitated <input type="checkbox"/> Yes <input type="checkbox"/> No	Choosing coverage for: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
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PCP provider ID number _____	Current patient <input type="checkbox"/> Yes	Dental provider office ID number _____	Current patient <input type="checkbox"/> Yes
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4	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Name (Last, first, middle initial) <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____	Sex (M/F) _____	Social Security number _____
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Birthdate (MM/DD/YYYY) / /	Incapacitated <input type="checkbox"/> Yes <input type="checkbox"/> No	Choosing coverage for: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
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PCP provider ID number _____	Current patient <input type="checkbox"/> Yes	Dental provider office ID number _____	Current patient <input type="checkbox"/> Yes
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Continued on next page

C. Individuals covered (Continued)

5	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Name (Last, first, middle initial)	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____	Sex (M/F)	Social Security number
	Birthdate (MM/DD/YYYY) / /	Incapacitated <input type="checkbox"/> Yes <input type="checkbox"/> No	Choosing coverage for: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		
	PCP provider ID number	Current patient <input type="checkbox"/> Yes	Dental provider office ID number	Current patient <input type="checkbox"/> Yes	

6	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Name (Last, first, middle initial)	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____	Sex (M/F)	Social Security number
	Birthdate (MM/DD/YYYY) / /	Incapacitated <input type="checkbox"/> Yes <input type="checkbox"/> No	Choosing coverage for: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		
	PCP provider ID number	Current patient <input type="checkbox"/> Yes	Dental provider office ID number	Current patient <input type="checkbox"/> Yes	

D. Dependent information

List any dependent in Section C with a different last name or 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
 If **yes**, will the Aetna coverage you're applying for replace the coverage you have now? Yes No

Name of person	Carrier name	Name of person	Carrier name

F. Medicare information

Name of person	Medicare Part A	Medicare Part B	Medicare Part D	Over age 65	Disability	End-stage renal disease effective 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. Declining coverage – Check all that apply.

I understand I am eligible to apply for this coverage through my employer; however, I am declining the coverage I checked below:

<input type="checkbox"/> Employee:	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Reason for declining coverage <input type="checkbox"/> Parental group coverage <input type="checkbox"/> Spouse / domestic partner group coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Retiree coverage <input type="checkbox"/> COBRA coverage <input type="checkbox"/> Insurance through another job <input type="checkbox"/> Indian Health Services <input type="checkbox"/> TRICARE / Military coverage <input type="checkbox"/> Individual coverage – On Exchange <input type="checkbox"/> Individual coverage – Off Exchange <input type="checkbox"/> Another group plan provided by my employer <input type="checkbox"/> Do not want <input type="checkbox"/> Other _____
<input type="checkbox"/> Spouse / domestic partner:	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	
<input type="checkbox"/> Child(ren):	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	

I certify I have been given the right to apply for this coverage; however, I am declining 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). <input type="checkbox"/> I am declining coverage. Employee signature: X	Date (Month/Day/Year)
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Please PRINT employee name:

Conditions of enrollment

On behalf of myself and the dependents listed, 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 Whole Health (AWH) Las Vegas HMO and HNOption plans: Aetna Health Inc. and Aetna Health Insurance Company
 - Aetna Open Access® Managed Choice (OAMC) plans and Aetna Indemnity plans: Aetna Life Insurance Company
 - Aetna VisionSM Preferred plans: Aetna Life Insurance Company; 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
 - Dental and other health coverages: Aetna Life Insurance Company.
2. I understand and agree that my employer's application will determine coverage and that there is no coverage until Aetna has approved both my employee enrollment form and the employer applications.
3. I understand and agree that this Enrollment / Change 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 Aetna or its agent information concerning the medical history, prescription utilization history, services or treatment provided to anyone listed on this Enrollment / Change 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 / domestic partner and competent adult dependents and I have obtained their consent to those terms. This authorization will remain valid for the term of the coverage and so long thereafter as allowed by law. I understand that I am entitled, as is any authorized representative that I may designate, to receive a copy of this authorization upon request and that a photocopy is as valid as the original. This authorization is voluntary. However, I understand that if I refuse to sign this authorization form, my ability to enroll in the 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 plans described above.
4. Authorizations signed for the purpose of collecting information in connection with this enrollment form for an insurance policy, a policy reinstatement or a request for a change in policy benefits shall remain valid for thirty (30) months from the date signed. Authorizations signed for the purpose of collecting information in connection with a claim for benefits shall remain valid for the term of this coverage or for so long as allowed by law. The information, as well as other personal or privileged information, subsequently collected by the insurance institution or agent may, in certain circumstances, be disclosed to third parties without authorization. A right of access and correction exists with respect to all personal information collected. Further disclosures required by Nevada law will be furnished to the policyholder upon request. Personal information may be collected from persons other than the individual or individuals proposed for coverage.
- t. 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.
6. I understand and agree that, with the exception of Aetna Rx Home Delivery® and Aetna Specialty Pharmacy®, all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, and Aetna Specialty Pharmacy, LLC, are subsidiaries 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.
7. I understand and agree that, with certain exceptions described in the plan documents, HMO plans and 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.

I represent that all information supplied in this form is true and complete. I have read and agree to the conditions of enrollment on this 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** 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 required for coverage.

If you wish to receive documents online, please visit your secure member account at aetna.com/individuals-families/aetna-navigator.html

Misrepresentation: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, denial of insurance and civil damages.

Please sign here ONLY if you are enrolling in coverage for yourself and / or dependent(s).

Employee signature (required)

Employee email

Date (Month/Day/Year)

Company name:
Employee name:

H. Health questionnaire must be completed for all individuals enrolling for coverage.

Health history for you and your dependents. *The following information is confidential and will not be seen by or given to your employer.*
 You or your dependents must answer ALL of the questions. Incomplete enrollment forms may delay the date your coverage starts.

1. Within the last five years, has anyone applying for coverage consulted with or received treatment from a doctor, psychiatrist, psychologist, or other practitioner or been diagnosed with any of the following conditions or disorders? (Check all that apply.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. <input type="checkbox"/> Diabetes b. <input type="checkbox"/> Infertility c. <input type="checkbox"/> Endocrine/metabolic d. <input type="checkbox"/> Pancreas e. <input type="checkbox"/> Liver / hepatitis f. <input type="checkbox"/> Immune system g. <input type="checkbox"/> Blood disorder h. <input type="checkbox"/> Hemophilia i. <input type="checkbox"/> Epilepsy / seizure j. <input type="checkbox"/> Heart k. <input type="checkbox"/> Paralysis / paresis l. <input type="checkbox"/> Tumor / cyst / growth m. <input type="checkbox"/> Systemic or discoid lupus n. <input type="checkbox"/> Lung or respiratory o. <input type="checkbox"/> Alcohol or drug use p. <input type="checkbox"/> Kidney / bladder / urinary q. <input type="checkbox"/> Circulatory / vascular r. <input type="checkbox"/> Digestive / stomach / intestinal s. <input type="checkbox"/> Central nervous system t. <input type="checkbox"/> Connective tissue disorder u. <input type="checkbox"/> Pituitary / adrenal / growth disorder v. <input type="checkbox"/> Birth defects / congenital abnormalities w. <input type="checkbox"/> Arthritis / bone / joint / muscle / prosthetic device x. <input type="checkbox"/> Mental / nervous / emotional / eating disorder y. <input type="checkbox"/> Stroke / brain / neurological z. <input type="checkbox"/> Transplant: <input type="checkbox"/> Recommended <input type="checkbox"/> Pending <input type="checkbox"/> Complete aa. <input type="checkbox"/> Advised to have <input type="checkbox"/> Tests, <input type="checkbox"/> Surgery, <input type="checkbox"/> Hospitalization or is <input type="checkbox"/> treatment needed, or <input type="checkbox"/> course of treatment not yet determined bb. <input type="checkbox"/> Cancer: Type: _____ Stage _____ <input type="checkbox"/> Surgery <input type="checkbox"/> Chemo <input type="checkbox"/> Radiation cc. <input type="checkbox"/> Using: <input type="checkbox"/> Crutches <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair dd. <input type="checkbox"/> Other _____	
2. Has any person listed on this enrollment form tested positive for exposure to the human immunodeficiency virus (HIV) or been diagnosed with acquired immune deficiency syndrome (AIDS) caused by HIV or other sickness or condition derived from this infection? Or has any person listed on this enrollment form been diagnosed with AIDS-related complex (ARC)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is anyone currently pregnant? Due date _____ Check applicable boxes: <input type="checkbox"/> C section planned <input type="checkbox"/> Multiple births expected (Number _____) <input type="checkbox"/> Complications: <input type="checkbox"/> Past or <input type="checkbox"/> Present	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has anyone applying for coverage had more than \$5,000 in medical expenses in the past 24 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Has anyone applying for coverage been prescribed medications in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Does anyone applying for coverage have a known condition that requires ongoing treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS IN SECTION H, YOU MUST COMPLETE SECTIONS I and J.

I. Health questionnaire – Details for "Yes" answers in Section H.

List all individuals enrolling for coverage.					
Name	Age	Height	Weight	Cigarette smoker	Currently taking prescription medication(s)
				<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
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

J. Provide details below to any boxes checked above. (If additional space is needed, attach a separate sheet and be sure to sign and date the sheet.)

Ques. No.	Name	Condition / diagnosis / treatment	Date of onset	Date treatment ended	Names of prescription medication	Dosage	Still taking medication
							<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

Employee signature (required)	Date (Month/Day/Year)
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