California Small Group Employee Enrollment/Change Form (1 - 100 employees)

PENDING REGULATORY APPROVAL

The following entities provide coverage: Aetna Health of California Inc. and Aetna Life Insurance Company for Aetna medical plans, Aetna Dental of California Inc. for Dental (DMO® only) and Aetna Life Insurance Company for all other coverages. For Vision coverage, First American Administrators, Inc. provides certain claims administration services. EyeMed Vision Care LLC ("EyeMed") provides certain network administration services.

PSUID or account number (if available)
Aetna member ID number (if available)

Company name	**INSTRUCTIONS:** You, the employee, must complete this enrollment form in full. If you do not, we will return it to you or your employer, and that can delay its processing. You alone are responsible for its accuracy and completeness. **If you are enrolling, please be sure to sign and date Employee signature on page 6. If you are declining coverage, you must complete section F on page 6.** Please use only black ink to complete this form.

Effective date **Date of hire**	☐ New hire ☐ Rehire/reinstatement ☐ New group enrollment ☐ Late enrollment ☐ Open enrollment ☐ Waiver	☐ Add spouse/dependent child ☐ Change of coverage ☐ Name change ☐ Other _____ Wherever the term "spouse" appears, it will be interpreted to include domestic partner.	☐ Employee termination ☐ Remove spouse/dependent child ☐ Cancel coverage Wherever the term "spouse" appears, it will be interpreted to include domestic partner.

☐ **COBRA** ☐ **Cal-COBRA** for: ☐ Employee ☐ Dependent Length of Continuation: ☐ 18 months ☐ 36 months ☐ Other _____

Qualifying event _____ Original qualifying event date _____ Loss of coverage date _____

A. Employee information – ***You must complete this section.*** **Please print clearly.**

Member Social Security number or tax ID number*	Last name, first name, middle initial		
Home address (PO box not acceptable)	Apt. number	City, state	ZIP code
Work address (PO box not acceptable)		City, state	ZIP code

Home/cell telephone ( ) -	Work telephone ( ) -	Primary language spoken (optional)	Number of dependents enrolling for medical coverage including spouse
Number of hours worked a week	Check one: ☐ Full time ☐ 1099 ☐ Seasonal ☐ Union ☐ Part time ☐ Retiree ☐ Temporary		Job title

*Social Security number is optional; tax identification number is acceptable. Please provide either Social Security number or tax identification number.

B. Coverage selection – ***Please print clearly.***

Control/Group number	Suffix	Account	Plan number

1. Medical coverage selection: Select a medical plan by checking the appropriate box below. (The plan must be offered by your employer.)

HMO Plans	
☐ CA Platinum HMO $25/50 0	☐ CA Gold HMO AVN $35/70 0
☐ CA Gold HMO $30/65 1250	☐ CA Silver HMO AVN $50/90 0
☐ CA Gold HMO $35/55 500	☐ CA Silver HMO AVN $55/90 2500 M
☐ CA Gold HMO $35/70 0	☐ CA Silver HMO AVN $65/85 2100
☐ CA Silver HMO $50/90 0	☐ CA Platinum HMO AWH SoCA $20/30 0 M
☐ CA Silver HMO $65/85 2100	☐ CA Platinum HMO AWH SoCA $25/50 0
☐ CA Bronze HMO $60/95 5800 M	☐ CA Gold HMO AWH SoCA $30/65 1250
☐ CA Bronze HMO $85/125 8550	☐ CA Gold HMO AWH SoCA $35/55 250 M
☐ CA Platinum HMO AVN $20/30 0 M	☐ CA Gold HMO AWH SoCA $35/55 500
☐ CA Platinum HMO AVN $25/50 0	☐ CA Gold HMO AWH SoCA $35/70 0
☐ CA Gold HMO AVN $30/65 1250	☐ CA Silver HMO AWH SoCA $50/90 0
☐ CA Gold HMO AVN $35/55 250 M	☐ CA Silver HMO AWH SoCA $55/90 2500 M
☐ CA Gold HMO AVN $35/55 500	☐ CA Silver HMO AWH SoCA $65/85 2100
Open Access Managed Choice Plans	
☐ CA Platinum MC 90/50 0 M	☐ CA Bronze MC 50/50 8300
☐ CA Platinum MC 80/50 250	☐ CA Gold MC Savings Plus 90/50 3400 HSA
☐ CA Gold MC 90/50 3400 HSA	☐ CA Gold MC Savings Plus 80/50 1000
☐ CA Gold MC 75/50 500	☐ CA Gold MC Savings Plus 80/50 1500
☐ CA Gold MC 80/50 1000	☐ CA Gold MC Savings Plus 80/50 350 M
☐ CA Gold MC 80/50 1500	☐ CA Gold MC Savings Plus 75/50 500
☐ CA Gold MC 80/50 350 M	☐ CA Silver MC Savings Plus 65/50 2500 M
☐ CA Silver MC 65/50 2500 M	☐ CA Silver MC Savings Plus 65/50 2700
☐ CA Silver MC 65/50 2700	☐ CA Silver MC Savings Plus 60/50 2100
☐ CA Silver MC 60/50 2100	☐ CA Bronze MC Savings Plus 100 7200 HSA M
☐ CA Bronze MC 100 7200 HSA M	☐ CA Bronze MC Savings Plus 50/50 8300
☐ CA Bronze MC 60/50 6250	
Open Choice PPO Plans	
☐ CA Gold PPO 80/50 1000	☐ CA Silver PPO 60/50 2100

Control/Group number	Suffix	Account	Plan number

2. Dental – *Check one (if applicable).*

Non-voluntary plans: ☐ Aetna Dental® Plan - Plan option _____ For *FOC, choose:* ☐ DMO® or ☐ PPO

Voluntary plans: ☐ Aetna Dental® Plan - Plan option _____ For *FOC, choose:* ☐ DMO® 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

Employees in AZ, CA, GA, MA, MD, MO, NC, NJ and TX must either live or work within the approved DMO® service area to be eligible to enroll in the DMO®.

Control number	Suffix	Account	Plan number

3. Aetna Vision℠ Preferred ☐ **Yes** ☐ **No**

You may only select a vision plan if your employer offers vision coverage.

C. Individuals Covered – ***List individuals for whom you are enrolling or adding/changing/removing coverage. Add more sheets if needed. For dependents with different last names or living at another address, complete Section D below.*** **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. Disabled children may be covered if they are over age 26. Please refer to your plan documents or contact your benefits administrator.

1	**Employee name** (last, first, middle initial)			Sex (M/F)	Birthdate (MM/DD/YYYY) / /	
Status ☐ Single ☐ Married ☐ Divorced ☐ Legally separated ☐ Domestic partnership	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision	Primary care physician (PCP) provider office ID number	Current patient ☐ Yes	Dental office ID number (if applicable)	Current patient ☐ Yes	
2	**Spouse name** (last, first, middle initial)	Sex (M/F)	Social Security number		Birthdate (MM/DD/YYYY) / /	
Relationship ☐ Spouse ☐ Domestic partner ☐ Other _____	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision	PCP provider office ID number	Current patient ☐ Yes	Dental office ID number (if applicable)	Current patient ☐ Yes	
3	**Child name** (last, first, middle initial)	Sex (M/F)	Social Security number		Birthdate (MM/DD/YYYY) / /	
Relationship ☐ Child ☐ Stepchild ☐ Other _____	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision	PCP provider office ID number	Current patient ☐ Yes	Dental office ID number (if applicable)	Current patient ☐ Yes	
4	**Child name** (last, first, middle initial)	Sex (M/F)	Social Security number		Birthdate (MM/DD/YYYY) / /	
Relationship ☐ Child ☐ Stepchild ☐ Other _____	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision	PCP provider office ID number	Current patient ☐ Yes	Dental office ID number (if applicable)	Current patient ☐ Yes	
5	**Child name** (last, first, middle initial)	Sex (M/F)	Social Security number		Birthdate (MM/DD/YYYY) / /	
Relationship ☐ Child ☐ Stepchild ☐ Other _____	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision	PCP provider office ID number	Current patient ☐ Yes	Dental office ID number (if applicable)	Current patient ☐ Yes	

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C. Individuals Covered ***(Continued)***

6	**Child name** (last, first, middle initial)	Sex (M/F)	Social Security number		Birthdate (MM/DD/YYYY) / /	
Relationship ☐ Child ☐ Stepchild ☐ Other _____	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision	PCP provider office ID number	Current patient ☐ Yes	Dental office ID number (if applicable)	Current patient ☐ Yes	
7	**Child name** (last, first, middle initial)	Sex (M/F)	Social Security number		Birthdate (MM/DD/YYYY) / /	
Relationship ☐ Child ☐ Stepchild ☐ Other _____	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision	PCP provider office ID number	Current patient ☐ Yes	Dental office ID number (if applicable)	Current patient ☐ 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

Conditions of enrollment

NOTICE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

I understand that the following legal entities (collectively referred to as "Aetna") underwrite the plans I apply for:

- Aetna Health of California Inc. and Aetna Life Insurance Company underwrite Aetna medical plans.
- Aetna Life Insurance Company underwrites Aetna Vision plans.
- Aetna Dental of California Inc. and Aetna Life Insurance Company underwrite Aetna Dental plans.

1. My employer's application determines coverage. I don't have coverage until Aetna approves my employee enrollment form and the employer application. Even if Aetna approves the employer application, any fraud, intentional misstatement or omissions of material facts may result in denial of future claims and Aetna may rescind or reevaluate my coverage under the policy, as of the effective date, for eligibility and rating purposes. If Aetna voids or rescinds coverage, I may be entitled to a refund of any paid premiums from the effective date of coverage. Aetna will give at least 30 days prior notice by certified mail to any covered person affected by the proposed rescission. However, after 24 months following the issuance of the policy, Aetna will not rescind the policy for any reason and will not cancel the policy, limit the policy, or raise premiums due on the policy due to misrepresentation or inaccuracies in this form, whether willful or not. Aetna does not base its eligibility rules for medical, dental or vision on any of the following factors:
   A. Health status
   B. Medical condition, including physical and mental illnesses
   C. Claims experience
   D. Receipt of health care
   E. Medical history
   F. Genetic information
   G. Evidence of insurability, including conditions arising out of acts of domestic violence
   H. Any other health status-related factor as determined by any federal regulations, rules, or guidance issued pursuant to Section 2705 of the federal Public Safety Act

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Conditions of enrollment *(Continued)*

2. The Group Agreement/Group Policy determines the rights and responsibilities of members and will govern in the event they conflict with any:
   - Benefits comparison
   - Summary
   - Other description of the plan
3. Participating physicians, hospitals and other health care providers are independent contractors. They are not Aetna agents or employees. We cannot guarantee the availability of any particular provider. Any provider network is subject to change. We will provide a notice of the change in accordance with applicable state law.
4. You may keep your medical information private by requesting a confidential communication.
5. I understand that, with certain exceptions described in the plan documents, HMO and DMO© plans only provide coverage for network covered benefits. The plan documents also describe if I need a referral for certain procedures, and who can provide care. Covered services must be performed by:
   - Participating primary care physicians
   - Participating primary care dentists
   - Participating specialists
   - Participating hospitals
   - Participating pharmacies
   - Participating dentists
   - Other participating providers as authorized by a referral from a participating primary care physician

To the best of my knowledge, 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 enrollment/change form. I understand in the event I fail to sign and return this form within 31 days of my eligibility date or Aetna does not receive the request within a reasonable time, my eligibility may be affected. I am employed by the employer shown on page 1. I am working full time at least 30 hours a week (or 20-29 hours a week if elected by my employer) for this employer at the regular place of business. I authorize deductions from my earnings for any contributions required for coverage. I agree to make any necessary payments as required for coverage.

To receive documents online, please visit your secure member account at Aetna.com.

For your protection, California law requires notice of the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Please sign here ONLY if you are enrolling in coverage for yourself and/or dependents.	***Employee email***	***Date (Month/Day/Year)***
☐ **I AM ENROLLING FOR COVERAGE:**		
Employee signature **X**		

If an Insurance Agent or Broker helped you complete this application, please obtain their signature below.

☐ **I did not use an Insurance Agent or Broker.**

Agent or broker certification and attestation:

I, _____(print name), attest to the following:

1. The information on the enrollment/change form is complete and accurate; and
2. I explained to the employee, in easy-to-understand language, the risk to the employee of providing inaccurate information and that the employee understood the explanation.

If you, as the agent or broker, willfully state as true any material fact(s) that you know to be false, you will, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to ten thousand dollars ($10,000).

Agent or broker signature: _____

F. 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.

☐ **Employee:**
☐ Medical ☐ Dental ☐ Vision

☐ **Spouse:**
☐ Medical ☐ Dental ☐ Vision

☐ **Children:**
☐ Medical ☐ Dental ☐ Vision

Reason for declining coverage

☐ Spouse group coverage
☐ Parental group coverage
☐ Medicare
☐ Medi-Cal
☐ 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
☐ Do not want
☐ Other _____

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 dependents.	***Date (Month/Day/Year)***
X I AM DECLINING COVERAGE: **Employee signature**	

Discrimination is Against the Law

Aetna complies with applicable California and Federal civil rights laws and does not discriminate on the basis of race, color, national origin, ethnic group, ancestry, religion, marital status, gender, gender identity, sexual orientation, age, disability, medical condition, genetic information, or sex (consistent with 45 CFR § 92.101(a)(2) and California 2 CCR § 14025). Aetna does not exclude people or treat them less favorably because of race, color, national origin, ethnic group, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, medical condition, genetic information, or disability.

Aetna:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services in a timely manner to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services in a timely manner to people whose primary language is not English, which may include:
    - Qualified interpreters
    - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call 1-800-872-3862 (TTY: 711) or the number on the back of your ID card.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ethnic group, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, medical condition, genetic information, or disability, by action or inaction, you can file a grievance with:

Civil Rights Coordinator
Attn: 1557 Coordinator
CVS Pharmacy, Inc.
1 CVS Drive, MC 2332, (HMO customers: P.O. Box 24030 Fresno, CA 93779)
Woonsocket, RI 02895
Phone: 1-800-648-7817, TTY: 711
Email: CRCoordinator@aetna.com

You can file a grievance in person, by mail, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

Please visit https://www.aetna.com/individuals-families/member-rights-resources/complaints-grievances-appeals.html#california for information about how to file a complaint or grievance with the California Department of Insurance or California Department of Managed Health Care (for HMO enrollees).
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
This notice is available at Aetna's website: https://www.aetna.com/.

"Aetna" is the brand name used for products and services provided by one or more of the Aetna group of companies offering and administering health and dental plans and other products such as life, disability, and long-term care insurance. In California, this includes Aetna's wholly-owned subsidiaries Aetna Life Insurance Company, Aetna Health of California Inc., Aetna Better Health of California Inc., Aetna Dental of California Inc., and Health and Human Resource Center Inc., and its other affiliates licensed in California. Aetna's ultimate parent is CVS Health Corporation ("CVS Health").

Language accessibility statement

Interpreter services are available for free.
TTY: 711

To access language services at no cost to you, call **1-800-385-4104**.

Para acceder a los servicios de idiomas sin costo, llame al **1-800-385-4104**. (Spanish)

如欲使用免費語言服務，請致電 **1-800-385-4104**. (Chinese)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số **1-800-385-4104**. (Vietnamese)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa **1-800-385-4104**. (Tagalog)

무료 언어 서비스를 이용하려면 1-800-385-4104 번으로 전화해 주십시오. (Korean)

Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք **1-800-385-4104** հեռախոսահամարով: (Armenian)

برای دسترسی به خدمات زبان به طور رایگان، با شماره **1-800-385-4104** تماس بگیرید. (Persian-Farsi)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону **1-800-385-4104**. (Russian)

言語サービスを無料でご利用いただくには、 **1-800-385-4104** までお電話ください。 (Japanese)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم **1-800-385-4104**. (Arabic)

ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, **1-800-385-4104** 'ਤੇ ਫ਼ੋਨ ਕਰੋ। (Punjabi)

ដើម្បីទទួលនសេវាផ្នែកភាសាដោយមិនគិតថ្លៃពីអ្នកសូមទូរសព្ទទលេខ 1-800-385-4104 ។ (Mon-Khmer, Cambodian)

Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu **1-800-385-4104**. (Hmong)

आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, **1-800-385-4104** पर कॉल करें। (Hindi)

หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-800-385-4104. (Thai)

Notice of Language Assistance

HMO and DMO-based plans:
IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-877-287-0117. Planes basados en DMO y HMO –

IMPORTANTE: ¿Puede leer esta carta? En caso de no poder leerla, le brindamos nuestra ayuda. También puede obtener esta carta escrita en su idioma. Para obtener ayuda gratuita, por favor llame de inmediato al 1-877-287-0117.

Traditional Plans:
No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-877-287-0117. For more help call the CA Dept. of Insurance at 1-800-927-4357 English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-877-287-0117. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish