



Group Insurance Enrollment Information

Aetna Life Insurance Company

SFO

Aetna Use Only

- Region 06
- Region 07

See Instructions on Reverse.

- New Enrollment
- Rehired Employee or Reinstatement of Coverage

1. Employer Name				4. Employer Address (Street, City, State, ZIP Code)			
2. Control Number	Suffix	Account	3. Claim Office Code				

5. Employee Name (Last, First, Middle Initial)			6. Social Security Number		7. Sex <input type="checkbox"/> M <input type="checkbox"/> F		8. Birthdate (MM/DD/YYYY) / /	
5a. Employee Address (Street, City, State)							5b. ZIP Code	

9. Beneficiary Designation (Example: Mary Jane Doe, NOT Mrs. John Doe) Full Beneficiary Name:				10. Relationship of Beneficiary		11. Occupation	
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12. Was the employee covered under a prior insurance plan during the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, complete below.				
Previous Insurance Company Name	Policy or Group Number	Effective Date of Prior Coverage	Termination Date of Prior Coverage	Insurance Company Phone Number

13. If coverage was as a dependent, the following must be provided.		
Name of the person under which you were insured.	That Person's Social Security Number	Will this coverage be kept after Aetna coverage begins? Employee <input type="checkbox"/> Yes <input type="checkbox"/> No / Dependent <input type="checkbox"/> Yes <input type="checkbox"/> No

14. Is the group insurance for this employee or any of their dependents being continued under COBRA, Extension of Benefits, or as a dependent of a deceased employee? Employee <input type="checkbox"/> Yes <input type="checkbox"/> No / Dependents <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide the name of the individual on continuation and the type of continuation:		What was the effective date of the continuation? Month Day Year / /
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15. Earnings Per <input type="checkbox"/> Annual <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Insurance Amt.	16. Plan Number	17. Full Time Employment or Return to Work Date (must be completed) Month Day Year / /	18. Effective Date (Employment Date Plus Probation Period) Month Day Year / /	19. Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Retired	20. Medicare Eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No
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21. Dependents - Please list all eligible dependents for which coverage is being requested.
 A. A dependent may be your spouse, or your unmarried biological or adopted child. Please complete a special dependent form for any other unmarried children who depend on you for support and live with you in a parent/child relationship.

Dependent's Full Name	Social Security Number	Relationship	Biological		Birthdate			*Other Ins. Coverage		Medicare Eligible?		**Full-Time Student	
			Adopted	Other	MM	DD	YYYY	Yes	No	Yes	No	Yes	No
_____	____ ____ ____ ____	_____	<input type="checkbox"/>	<input type="checkbox"/>	____ ____ ____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
_____	____ ____ ____ ____	_____	<input type="checkbox"/>	<input type="checkbox"/>	____ ____ ____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
_____	____ ____ ____ ____	_____	<input type="checkbox"/>	<input type="checkbox"/>	____ ____ ____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
_____	____ ____ ____ ____	_____	<input type="checkbox"/>	<input type="checkbox"/>	____ ____ ____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
_____	____ ____ ____ ____	_____	<input type="checkbox"/>	<input type="checkbox"/>	____ ____ ____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

B. Are any of the dependents to be covered medically confined (in a hospital, at home or elsewhere)? Yes No If Yes, please provide the name of the dependent child and the reason for confinement:

C. *Other (or Prior) Insurance Coverage - If Yes was checked above in Item 21A, or if any listed dependent has had other health coverage at any time during the past 12 months, the information requested in Items 12-13 above (for the employee) **must** be provided here for each such dependent. Use Item 22 - Special Remarks - if additional space is required.

D. ** Full Time Student - If Yes was checked above in Item 21A, please provide the name of the school and anticipated graduation date.

22. Special Remarks (Use for further explanations concerning Items 1 - 21.)

23. **ACKNOWLEDGMENTS** - I am presently employed and qualify as an eligible employee according to the terms of my employer's plan of benefits, understand that misstatements, misrepresentations or omissions may result in my insurance coverage being void as of its effective date with no benefit payable, and that any contributory group insurance is not effective until this form is approved by Aetna Life Insurance Company. I hereby request the group insurance coverage for which I am eligible and authorize deductions from my earnings to serve as payment for any required contributions. My signature below affirms that all information and statements provided on this form are full, complete and true to the best of my knowledge.
Fraud Warning Notice: Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits a request for enrollment or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

Employee Signature	Employee E-mail Address	Date
Employer Signature	Date	

Instructions For Completing Group Insurance Enrollment Information

At the top of the form, check the "New Enrollment" or "Rehired Employee or Reinstatement of Coverage" box, as appropriate.

To Enroll (New or Reinstatement Applicants)

EMPLOYER: Please fully complete Items 1 - 4 and Items 14 - 20 and provide an authorized signature in Item 23.

- Item 1: **Employer Name** – Provide full name of business or organization.
- Item 2: **Control, Suffix and Account Number** – For enrollees of new customers, the number will be assigned by Aetna; for subsequent enrollments, the number will be the same as shown on the premium statement.
- Item 3: **Claim Office Code** – Leave blank; will be assigned by Aetna.
- Item 4: **Employer Address** – Provide the employer's address.
- Item 14: **Continuation of Coverage** – Complete if applicable.
- Item 15: **Employee Earnings** – Consult your Aetna representative or administration material to identify if earnings need to be reported. Enter the rounded dollar amount and check the box of the required frequency.
- Item 16: **Plan Number** – For enrollees of new customers, the number will be assigned by Aetna; for subsequent enrollments, refer to your Plan Sheet to determine the correct Plan Number.
- Item 17: **Employment/Return to Work Date** – This **must** be completed.
- Item 18: **Effective Date of Coverage** – Indicate the requested effective date of coverage.
- Item 19: **Employment Status** – Check the appropriate box(es). Coverage for part time employees is at the election of the employer.
- Item 20: **Medicare Eligibility** – Based on employee's age or disabled status; check the appropriate box.

EMPLOYEE: Please fully complete Items 5 - 13 and Items 21 - 23.

- Items 5 - 8: Provide appropriate information. (NOTE: Date of birth should include the **four digit year of birth**.)
- Items 9 - 10: **Beneficiary Name and Relationship** – Provide full given name of the beneficiary and his/her relationship to the employee. If more than one beneficiary, omit Item 9 and fully detail the designation in Item 22, Special Remarks. If beneficiary is a trust agreement, use Item 22 to provide: 1) Full Name of Trust, 2) Trustee, and 3) Trust Agreement Date. If beneficiary is a charitable organization, provide the full name and address of the organization.
- Other examples: • Mary J. - Wife, if she survives me, otherwise, my surviving children
• John and Susan - Children
- Item 11: Provide appropriate information.
- Items 12 - 13: **Other (or Prior) Health Coverage** – Both sections **must** be completed or the form will be returned. Fully complete with requested information or write "None" in both Items if that applies.
- Item 21: **Dependents** – Carefully read the definition of eligible dependents and complete Items A through D as applicable. NOTE: Date of birth should include the **four digit year of birth**.
- 21A: Other Insurance Coverage** - Check "Yes" if the dependent will have other group health coverage in addition to this coverage. Otherwise, check "No." This **must** be completed.
- 21C: Other (or Prior) Insurance Coverage** - This **must** be completed for each dependent that currently has, or has had at any time during the previous 12 months, any other health coverage. If Items 21C and 22 do not allow sufficient space, attach a separate sheet with the Group (Control) Number and employee name and Social Security Number written on the top of the sheet. Provide any additional information on that sheet.
- 21D: Full Time Student** - Complete only if dependent child is age 19 years or older and regularly attending school.
- Item 23: **Acknowledgment** – Carefully read the acknowledgment statements and sign and date the form.

For additional assistance in completing this form, contact your Customer Service Representative.