Enrollment/Change Request

Aetna US Healthcare

Aetna Life Insurance Company **

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
ALTMAN PLANTS, INC					

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

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		( ) ___-___	( )			

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 Entrnt	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*	ID # / Name	Yes
			___-___-___	/ /		☐	☐	☐	☐	N/A	N/A	ID # / Name	☐
			___-___-___	/ /		☐	☐	☐	☐	☐	☐	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 ___

Authorization of Enrollee

Disclosure of Healthcare Information	I authorize any physician/dentist, other healthcare professional, hospital, other healthcare institution and my employer to disclose, at any time and to the extent allowed by law, to Aetna Life Insurance Company or an affiliated entity ("Aetna"), information concerning healthcare (including dental) advice, treatment or supplies provided to my spouse or dependents or to myself, including those involving mental health, substance abuse and HIV/AIDS ("healthcare information").
Redisclosure of Healthcare Information	I also authorize Aetna to redisclose the healthcare information to my employer, healthcare professionals and institutions, independent claims administrators, utilization review organizations and reinsurers or other insurers with which Aetna has contracted.
Purpose of Disclosure/ Redisclosure	The healthcare information will be used for the coordination of patient care, administration of benefits, quality managemen and audit of services, and for fulfilling obligations imposed on Aetna by contract or law.
Dependents' Authorization	I have discussed the terms of this authorization with my spouse and competent adult dependents, and I have obtained their consent to the release of their healthcare information pursuant to this authorization.
Insured's Rights	I understand that I may review and offer corrections to the healthcare information, except information about me or my dependents that relates to claims or civil or criminal proceedings involving me or my dependents. I also understand I may revoke this authorization at any time, except to the extent it has been relied on by Aetna or other party. In addition, I understand that I may receive a copy of this authorization and that a copy of this authorization is as valid as the original.
Duration of Authorization	This authorization shall remain valid for the term of this coverage or for so long as allowed by law.
Payroll Deductions and Other Payments	I request the coverage which I have indicated and for which I am eligible. I authorize deductions from my earnings for any contributions required for healthcare coverage, and I agree to make any necessary payments as required for coverage.
Independent Contractors	Applicant acknowledges that Aetna Life Insurance Company's participating providers, including all participating primary care dentists, are independent contractors and are neither agents nor employees of Aetna Life Insurance Company.

** Aetna U.S. Healthcare DMO, Aetna U.S. Healthcare PPO Dental and Aetna U.S. Healthcare Indemnity Dental are underwritten by Aetna Life Insurance Company. In Arizona, Aetna U.S. Healthcare DMO may also be underwritten by Aetna U.S. Healthcare, Inc. (AZ).