aetna® Aetna AFA Medical and Stop Loss Employee Enrollment/Change Form

Effective Date	Date of Hire	Member ID Number (if available)

Employer Name	Instructions: You, the employee, must complete the application in full or it will be returned to you, resulting in a delay in processing. You are solely responsible for its accuracy and completeness. **If waiving coverage, please complete Sections A and F.**

☐ New Hire ☐ Rehire/Reinstatement ☐ New Group Enrollment ☐ Late Enrollment ☐ Waiver ☐ Open Enrollment ☐ Other _____	☐ Change of Coverage ☐ Add Spouse ☐ Add Civil Union (state specific) ☐ Add Domestic Partner (state specific) ☐ Add Dependent Child ☐ Name Change ☐ Other _____	☐ Employee Termination ☐ Remove Spouse ☐ Remove Civil Union (state specific) ☐ Remove Domestic Partner (state specific) ☐ Remove Dependent Child ☐ Cancel Coverage	☐ **COBRA for:** ☐ Employee ☐ Dependent Length of Continuation: ☐ 18 ☐ 36 ☐ Other ____ Original Qualifying Event Date _____ Qualifying Event _____ Reason _____

A. Employee Information

Social Security Number	Last Name, First Name, M.I.	Home Telephone	Email Address (if we may correspond with you via email)
779062036	KIRAN,RAGHU	7864594341	raghukiran@hotmail.com

Home Address	Apt. No.	City, State	ZIP code
151 SOUTH EAST ST	214	INDIANAPOLIS,IN	46202

Work Address	City, State	ZIP code	Work Telephone
220 VIRGINIA AVENUE	INDIANAPOLIS,IN	46201	7864594341

Number of Hours Worked Per Week 40 | Check One: ☑ Full Time ☐ Part Time ☐ 1099 ☐ Retiree ☐ Seasonal ☐ Temporary ☐ COBRA ☐ Union

B. Medical Coverage Selection

Plan Option _____

C. Dependent Information – *List any dependent living at another address.*

Name	Address	Name	Address

D. Other Medical Coverage – *List any individuals who will have other health insurance at the same time as this coverage.*

Name of Person	Carrier Name	Name of Person	Carrier Name

E. Medicare Coverage – *List individuals covered by Medicare.*

Name of Person	Medicare Part A	Medicare Part B	Medicare Part D	Over Age 65	Disability	End-Stage Renal Disease Effective Date
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

F. Decline/Waive – *To be completed if medical coverage is declined or refused by an eligible employee and/or their eligible family members.*

Medical Coverage Declined for:
☐ Myself
☐ Spouse/Civil Union/Domestic Partner
☐ Children

Reason for declining coverage
☐ Parental coverage
☐ COBRA coverage
☐ Retiree coverage
☐ TRICARE
☐ Medicare
☐ Medicaid
☐ VA coverage
☐ Spousal/Civil Union/Domestic Partner group coverage
☐ Another group plan provided by my employer
☐ Insurance through another job
☐ Individual coverage – On or Off Exchange
☐ Do not want
☐ Other _____

I acknowledge I have been given the right to apply for this coverage, however, I am electing not to enroll. 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. I and/or my dependents have made this decision of my/their own accord, with no pressure from my employer, my employer's agent or the insurance carrier.

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

X Employee Signature _____

Date (Month/Day/Year) _____

G. Individuals Enrolling – List individuals enrolling or adding/changing/removing coverage. If more space is needed check here ☐ and use a separate sheet of paper.

(A)dd (C)hange (R)emove	Name (Last, First, M.I.)	Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY)	Height	Weight	Tobacco Use (including eCigarette devices)	Currently Taking Prescription Medication(s)	Incapacitated
	☐ Employee 1.						☐Yes ☐No	☐Yes ☐No	☐ Yes ☐No
	☐Spouse ☐ Domestic Partner 2.						☐Yes ☐No	☐Yes ☐No	☐ Yes ☐No
	☐Child ☐ Stepchild ☐Other 3.						☐Yes ☐No	☐Yes ☐No	☐ Yes ☐No
	☐Child ☐ Stepchild ☐Other 4.						☐Yes ☐No	☐Yes ☐No	☐ Yes ☐No

H. Health Questionnaire – Complete for all individuals enrolling for coverage.

Have you or anyone applying for coverage consulted with or been examined, diagnosed, or treated by any health care professional during the last five (5) years for any illness, injury or health condition in any of the categories listed below? If "Yes," please check the box that most appropriately describes the condition(s), **circle** the applicable condition(s), and explain fully below.

1. **Bone / Muscle**: Arthritis, Back/Neck/Spine problems, Joint disorders, Joint replacement, Herniated disc, Other. **Brain / Nervous:** Epilepsy (Seizures), Paralysis/Paresis, Pituitary disorder, Stroke, Other. **Heart / Circulatory:** Chest pain, Congestive Heart Failure, Heart Attack, Heart Disease, Hemophilia, High Blood Pressure, Sickle Cell Disease, Other. **Immune:** AIDS/HIV, Connective Tissue Disorder, Immunodeficiency, Systemic or Discoid Lupus, Other. **Intestinal / Endocrine**: Adrenal disorder, Cirrhosis, Crohn's, Diabetes Type I or Type II, Digestive disorder, GERD (reflux), Hepatitis B, C, or other, Liver or Pancreas disorder, Stomach ulcer, Ulcerative Colitis, Other. **Lung / Respiratory**: COPD, Emphysema, Other. **Substance Abuse**: Alcohol or Drug Abuse. **Reproductive**: Infertility, Pregnant-normal birth expected, Pregnant-high risk, Pregnant-multiple births expected, Other. **Transplant:** Organ or Bone Marrow Transplant (planned, recommended or already performed). **Tumor:** Fibroids (location), Other. **Urinary:** Bladder disorder, Dialysis, Kidney failure, Kidney stones, Other. **Other:** Birth defect/Congenital abnormality, Growth disorder (including Dwarfism or receiving growth hormones), Paralysis or Paresis, Prosthesis, Other.	☐Yes ☐No
2. Cancer: Type _____ Stage _____ **Check applicable boxes**: ☐ Surgery date _____ ☐ Chemo end date _____ ☐ Radiation end date _____	☐Yes ☐No
3. Is anyone applying for coverage been advised they need future hospitalization or have surgical procedures been planned, discussed, or recommended, or has any other medical condition which has not been disclosed? Provide full details below.	☐ Yes ☐No

IF YOU ANSWERED "YES" TO ANY QUESTIONS, PLEASE EXPLAIN BELOW. (If additional space is needed, attach a separate sheet. All attachments must be signed and dated by the applicant.)

Ques. No.	Enrollee Name	Conditions, Diagnosis & Treatments	Start Date	End Date	Medications (include name and oral, injectable, or infusion)	Dosage	Is Treatment Ongoing? If YES, provide details of any current OR future treatment.

Conditions of Enrollment

I understand and agree that my employer's application will determine coverage and that there is no coverage unless and until Aetna approves both this enrollment form and the employer application. I agree that my employer or its agent may send this enrollment form to Aetna. I authorize all my doctors, pharmacies, hospitals and other health care providers ("Providers") to give Aetna any and all personal health information about me and others listed on this form. This authorization covers all health matters including those involving mental health, substance abuse and HIV/AIDS. 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 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 to receive a copy of this authorization upon request and that a photocopy is as valid as the original.

I certify that all information and statements on this enrollment form are true and complete to the best of my knowledge and that I have authority to make statements on behalf of any dependents listed on this form. I am employed by the employer on page 1 and working full-time for this employer.

I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Employee Signature	Date
raghukiran	05/11/2018