aetna®

Aetna Vision℠ Preferred Enrollment/Change Request

Aetna Life Insurance Company

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Instructions: Refer to the instructions section on the back before completing this form. You must complete this 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.

Employer Group Information (To Be Completed by Employer)	Control	Suffix	Account	Plan Number

Employer Name – Full Name of Business or Organization

Employer Address (Street, City, State, ZIP Code) – Primary Location of Business or Organization

A. Type of Activity – Employee Completes Sections A – E. *Please Print Clearly.*

Enrollment – *Check one.*
- ☐ New Enrollee/Subscriber

Effective Date: ____/____/____

Date of Hire: ____/____/____

- ☐ Rehire/Reinstatement

Date of Rehire/ Reinstatement ____/____/____

Change – *Check all that apply.*
- ☐ Add Spouse
- ☐ Add Dependent Child
- ☐ Name Change
- ☐ Other _____
- ☐ Control/Suffix/Acct/Plan: _____

Date of Event: ____/____/____

Reason: _____

Remove or Terminate – *Check all that apply.*
- ☐ Remove Spouse
- ☐ Remove Dependent Child
- ☐ Employee Withdrawal/ Termination
- ☐ Cancel Coverage

Effective Date: ____/____/____

Reason: _____

Continuation of Coverage, i.e., COBRA, State
Not all options are available. Contact Employer for available options.

Coverage for: ☐ Employee ☐ Dependents

Length of Continuation (months):
- ☐ 18 ☐ 36 ☐ Other _____
- ☐ 29 – Attach disability determination from the Social Security Administration

Date of Loss of Coverage: ____/____/____

Date of Qualifying Event: ____/____/____

Continuation of Coverage Expiration Date: ____/____/____

B. Employee Information

Social Security Number	Last Name, First Name, M.I.		Home Telephone	Work Telephone
Employee Status ☐ Active ☐ Retired	Home Address	Apt. No.	City, State	ZIP Code

Subscriber Primary Language (other than English) Primer Idioma del suscriptor (que no sea el Ingles)	Subscriber Disability
What is your primary Language? ¿Cuál es su primer idioma?	Do you have a disability which affects your ability to communicate or read? ☐ Yes ☐ No If Yes, please indicate the nature of your disability.

C. Product Information

☒ Aetna Vision℠ Preferred

Aetna Vision℠ Preferred may not be available in all states.

D. Individuals Covered - *List individuals for whom you are enrolling or adding/changing/removing coverage.*

☐ Check this box if you are refusing coverage for your dependents. ** Provide details for "Yes*" responses below.*

(A)dd (C)hange ____ (R)emove	1. Employee Name - Last, First, M.I.			Relationship Code **Self**	Sex (M/F)
Birthdate (MM/DD/YYYY) / /	Social Security Number	Other Vision Coverage Yes* ☐	Currently Covered by Medicare Yes* ☐	Handicapped N/A	Student N/A

(A)dd (C)hange ____ (R)emove	2. Spouse Name - Last, First, M.I. (Explain difference in last name in Special Remarks.)			Relationship Code	Sex (M/F)
Birthdate (MM/DD/YYYY) / /	Social Security Number (if dependent has no SSN, write "None")	Other Vision Coverage Yes* ☐	Currently Covered by Medicare Yes* ☐	Handicapped Yes ☐	Student Yes ☐

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D. Individuals Covered – (continued) *List individuals for whom you are enrolling or adding/changing/removing coverage.*
** Provide details for "Yes*" responses below.* Attach sheet to list additional children.

(A)dd (C)hange (R)emove ____	3. Child Name - Last, First, M.I. (Explain difference in last name in Special Remarks.)			Relationship Code	Sex (M/F)
Birthdate (MM/DD/YYYY) / /	Social Security Number (if dependent has no SSN, write "None")	Other Vision Coverage Yes* ☐	Currently Covered by Medicare Yes* ☐	Handicapped Yes ☐	Student Yes ☐

(A)dd (C)hange (R)emove ____	4. Child Name - Last, First, M.I. (Explain difference in last name in Special Remarks.)			Relationship Code	Sex (M/F)
Birthdate (MM/DD/YYYY) / /	Social Security Number (if dependent has no SSN, write "None")	Other Vision Coverage Yes* ☐	Currently Covered by Medicare Yes* ☐	Handicapped Yes ☐	Student Yes ☐

(A)dd (C)hange (R)emove ____	5. Child Name - Last, First, M.I. (Explain difference in last name in Special Remarks.)			Relationship Code	Sex (M/F)
Birthdate (MM/DD/YYYY) / /	Social Security Number (if dependent has no SSN, write "None")	Other Vision Coverage Yes* ☐	Currently Covered by Medicare Yes* ☐	Handicapped Yes ☐	Student Yes ☐

(A)dd (C)hange (R)emove ____	6. Child Name - Last, First, M.I. (Explain difference in last name in Special Remarks.)			Relationship Code	Sex (M/F)
Birthdate (MM/DD/YYYY) / /	Social Security Number (if dependent has no SSN, write "None")	Other Vision Coverage Yes* ☐	Currently Covered by Medicare Yes* ☐	Handicapped Yes ☐	Student Yes ☐

1. If "Yes" to Other Vision Coverage and/or Currently Covered by Medicare above, provide effective dates, name & policy number of insurance carrier, vision plan or other source & your Member Identification Number.

2. Does any dependent listed above live at a different address than the employee? ☐ Yes ☐ No If "Yes," who & what address?

Special Remarks:

E. Race/Ethnicity - Optional (This information is designed for the purpose of data collection & will not be used for determining eligibility, rating or claim payment.)

Employee 1.	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____	Child 4.	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____
Spouse 2.	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____	Child 5.	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____
Child 3.	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____	Child 6.	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____

Conditions of Enrollment

Applicant Acknowledgments and Agreements

On behalf of myself and the dependents listed on Pages 1 and 2, I agree to or with the following:

1. I acknowledge that by enrolling in an Aetna Vision℠ Preferred plan, coverage is underwritten by Aetna Life Insurance Company (referred to as "Aetna") and that 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.
2. I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments as required for coverage.
3. I understand and agree that this Enrollment/Change Request may be transmitted to Aetna or its agent by my employer or its agent. I authorize any physician, optometrist, other healthcare professional, hospital or any other healthcare organization ("Providers") to give Aetna or its agent information concerning the medical history, services or treatment provided to anyone listed on this Enrollment/Change Request form, 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. I understand that this authorization is provided under state law and that it is not an "authorization" within the meaning of the federal Health Insurance Portability and Accountability Act. This authorization will remain valid for 30 months from the date I sign it or in the case of the information described above being collected in connection with a medical claim, this authorization will be valid for the term of the coverage. I understand I or my authorized representative is entitled to a copy of this authorization upon request and that a photocopy is as valid as the original.
4. 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.
5. I understand and agree that, with the exception of Aetna Rx Home Delivery®, all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary 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.

Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive 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 act, which is a crime and subjects such person to criminal and civil penalties.

☐ *By checking this box you agree to use Aetna Navigator®, Aetna's member self-service website for all future printed materials and understand you may choose to receive paper documents in the future.*

Employee Signature

I certify that all information supplied in this form is true and complete to the best of my knowledge and belief. I have read and agree to the Conditions of Enrollment and Misrepresentation on this Employee Enrollment/Change Request form.

Employee Signature - Required	*Date (Month/Day/Year)*	*Employee E-mail Address (optional)*
X	/ /	

Employer Verification (To Be Completed by Employer)

Employer Signature - Required	*Title*	*Date (Month/Day/Year)*
X		/ /

Instructions

Employer

- Complete the **Employer Group Information** at the top of Page 1.
- Complete the **Employer Verification** below the Employee signature on Page 3. Employer must sign & date the Enrollment/Change Request for new enrollments or coverage changes to be processed.

Employee – Complete Sections A – E. Additional dependent and/or other information may be provided on a separate sheet. All attachments must be signed and dated.

Section A – Type of Activity:

- Check box(es) indicating reason(s) for submitting this Enrollment/Change Request.
- Provide Effective Date(s) & Date of Event(s) where requested.

Section B – Employee Information:

- Complete **all** information in order for your Enrollment/Change Request to be processed.

Section C – Product Information

Section D – Individuals Covered:

- Add/Change/Remove – Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the names(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, & Social Security Number for each individual.
  - *Relationship Code* – Use ONLY: H=Husband, W=Wife, S=Son, D=Daughter, Y=Sponsored Male, X=Sponsored Female. **If the dependent is NOT your spouse or a biological or legally adopted child, please indicate relationship to employee in Special Remarks.**
- If you or your dependent(s) have **Other Vision Coverage** and/or are **Currently Covered by Medicare**, check the "Yes" box(es) and provide beginning & ending effective dates, name & policy number of insurance carrier, vision plan or other source & your **Member Identification Number** for the insurance plan in the space provided in Number 1.
- If a dependent is Handicapped & financially dependent, check "Yes" & provide proof of handicapped status from the attending physician.
- If a dependent is a Student, check "Yes". Refer to your Summary Coverage for plan definitions. Aetna may request that you provide proof from the educational institution.

Section E – Race/Ethnicity (Optional): Check the appropriate Race/Ethnicity code for each individual. If your Race/Ethnicity is "Other," print the Race/Ethnicity for each individual in the space provided.

Conditions of Enrollment/Misrepresentation – Employee Signature: Employee must sign & date the Enrollment/Change Request for new enrollments or coverage changes to be processed.