aetna℠

MedPremier
Enrollment/Change Request
Insurance plans are underwritten by Aetna Life Insurance Company (Aetna).

ActOne Government Solutions
MedPremier Plan

TO COMPLY WITH CALIFORNIA LAW, THE TERM "SPOUSE" SHALL BE CONSTRUED TO INCLUDE A DOMESTIC PARTNER.

Instructions: Read and fill out the Enrollment/Change Request (all pages). Make a copy for yourself. Please follow the instructions on your welcome letter regarding form submission.

INFORMATION ABOUT YOU Complete all information.

Print your name (first, middle initial, last)			Social Security Number	Date of birth (MM/DD/YYYY)
Home address	Apartment Number	City	State	Zip code
Home phone ( )	Work phone ( )	Email address	Sex ☐ Male ☐ Female	Primary language spoken (Idioma principal)

ACTION YOU WANT TO TAKE Check the box next to the action you want to take.

I am not currently enrolled and I want to…	☐ **Enroll** in the coverage choices selected below.
I am currently enrolled and I want to…	☐ **Update** my personal and/or my dependent and/or beneficiary information.

YOUR COVERAGE CHOICES Check(☑) the box for the level of coverage you want.

Coverage Type	Coverage Level	Weekly Cost
Medical	☐ Employee Only	$0.00
	☐ Employee + Spouse	$169.40
	☐ Employee + Child(ren)	$137.98
	☐ Employee + Family	$294.37

EMPLOYER GROUP INFORMATION This section is to be completed by your employer.

Employee ID	Hire date (MM/DD/YYYY)	Pay type	Total deduction ($)	**Effective date** (MM/DD/YYYY)
Location or site code	Authorized signature		Title	Today's date (MM/DD/YYYY)

INFORMATION ABOUT YOU Repeat your name and Social Security number here.

Print your name (first, middle initial, last) | Social Security Number

[INFORMATION ABOUT YOUR DEPENDENTS List the dependents for whom you are adding/changing/removing coverage.

If you have more dependents, write down their information on a separate sheet and attach it to this Enrollment/Change Request.

☐ Add ☐ Change ☐ Remove

Print dependent's name (first, middle initial, last) | Social Security Number

Sex ☐ Male / ☐ Female | Date of birth

Relationship: ☐ Spouse ☐ Domestic partner ☐ Child ☐ Other (Specify): _____

Address (if different than yours) | City | State | Zip code

☐ Add ☐ Change ☐ Remove

Print dependent's name (first, middle initial, last) | Social Security Number

Sex ☐ Male / ☐ Female | Date of birth

Relationship: ☐ Spouse ☐ Domestic partner ☐ Child ☐ Other (Specify):

Address (if different than yours) | City | State | Zip code

☐ Add ☐ Change ☐ Remove

Print dependent's name (first, middle initial, last) | Social Security Number

Sex ☐ Male / ☐ Female | Date of birth

Relationship: ☐ Spouse ☐ Domestic partner ☐ Child ☐ Other (Specify): _____

Address (if different than yours) | City | State | Zip code

MAKING CHANGES OUTSIDE OF AN OPEN ENROLLMENT Please read below to see if you are able to make changes to your coverage.

You can add to or increase your coverage during the plan year only if you have a **Qualifying Life Event (QLE)**. QLEs fall under one of these two categories:

Loss of Other Coverage (LOC): If you previously declined health coverage because you or your dependents were already covered under another health plan and you or your dependents have lost that other coverage, you may be able to enroll yourself and your dependents. If you had a recent LOC, go to the list on the right and check the box next to your LOC and supply the date of the LOC.

Family Status Change (FSC): Whether you are currently enrolled or previously declined coverage, you may be able to add or increase coverage when you experience certain FSC events. If you had a recent FSC, go to the list on the right and check the box next to your FSC and supply the date of the FSC.

[Next, complete the rest of this Enrollment/Change Request. When finished, make a copy and submit it to your employer with your documentation attached. You must submit this Enrollment/Change Request, together with documentation, to your employer within [31] days of the LOC/FSC.

Loss of Other Coverage (LOC):
- ☐ Divorce, legal separation or death
- ☐ Termination of employment of a dependent
- ☐ Reduction of a dependent's hours
- ☐ Termination of your or your dependents' COBRA rights
- ☐ Loss of employer's contribution to spouse's or domestic partner's coverage
- ☐ Dependent child losing eligibility as a dependent
- ☐ Other loss of coverage

Family Status Change (FSC):
- ☐ Divorce, legal separation or death
- ☐ Marriage
- ☐ Birth or adoption of a dependent
- ☐ Other

Date of LOC or FSC (mm/dd/yyyy)

YOUR AUTHORIZATION You must sign and date this Enrollment/Change Request for all new enrollments or coverage changes.

I represent that all information supplied in this Enrollment/Change Request is true and complete to the best of my knowledge and/or belief. I have read and agree to the Conditions of Enrollment on the last page of this Enrollment/Change Request.

Your signature | Today's date (MM/DD/YYYY)

CONDITIONS OF ENROLLMENT Applicant acknowledgments and agreements

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

On behalf of myself and the dependents listed on this Enrollment/Change Request, I agree to or with the following:

1. I acknowledge that by enrolling in an Aetna plan coverage is underwritten and administered by Aetna Life Insurance Company (Aetna) 151 Farmington Avenue, Hartford, CT 06156.
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, 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, including those involving mental health, substance abuse and 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 or domestic partner 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 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.
4. The plan documents will determine the rights and responsibilities of covered person(s) and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
5. **Attention California Residents: For your protection California law requires notice of the following to appear on this form**: The falsity of any statement in this Enrollment/Change Request shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by Aetna.
   Attention Pennsylvania Residents: 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.
   Attention Rhode Island Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.