NOTE: Before submitting this completed form to your employer, you may wish to protect the confidentiality of your health information by taping or stapling the form so the health information pages are not visible.

aetna®

Georgia Employee Enrollment/Change Form
(2 - 50 Eligible Employees)

INSTRUCTIONS: You, the employee, must complete this enrollment form 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 B and F.**

Member Aetna ID Number (if available)

Company Name Aberdeen Dental

Effective Date / / **Date of Hire** / /	☐ New Hire ☐ Rehire/Reinstatement ☐ New Group Enrollment ☐ Late Enrollment ☐ Other _____	☐ Change of Coverage ☐ Add Spouse/Domestic Partner ☐ Add Dependent Child ☐ Name Change ☐ Other _____	☐ Employee Termination ☐ Remove Spouse/ Domestic Partner ☐ Remove Dependent Child ☐ Cancel Coverage	☐ COBRA ☐ State Continuation for: ☐ Employee ☐ Dependent Length of Continuation: ☐ 18 ☐ 36 ☐ Other ____ Original Qualifying Event Date _____ Qualifying Event _____

A. Coverage Selection – *Please print clearly, using black ink.* *(Shaded sections for Employer/Aetna Use Only)*

Control/Group No.	Suffix	Account	Plan No.	Class Code

[1. **Medical** ☐ Yes ☐ No
- ☐ **HNOnly (HMO OA)** – Plan: _____
- ☐ **Managed Choice Open Access** – Plan: _____
- ☐ **PPO** – Plan: _____
- ☐ **Indemnity** – Plan: _____]

Control/Group No.	Suffix	Account	Plan No.	Class Code

[2. **Dental** ☐ Yes ☐ No *Enter plan number and name below.*

Standard Plans:
Plan Number: _____
Plan Name: _____
If FOC, check: ☐ DMO® *or* ☐ PPO

Voluntary Plans:
Plan Number: _____
Plan Name: _____
If FOC, check: ☐ DMO® *or* ☐ PPO

Before today, were you covered under this employer's dental plan? ☐ Yes ☐ No]

Control/Group No.	Suffix	Account	Plan No.

[3. **Life and Disability** ☐ Yes ☐ No *Check applicable boxes.*

NOTE: Disability coverage is for employee only. Disability plans do not cover dependents.

☐ Basic Life/AD&D Ultra® ☐ Optional Dependent Life ☐ Life & Disability Packaged Plan ☐ Short Term Disability

Full Beneficiary Name (First, Middle, Last)	Beneficiary Social Security Number	Birthdate (MM/DD/YYYY) / /
Beneficiary Address (Number, Street, **Apt. No.**, City, State, ZIP Code)	Telephone Number ( ) -	Relationship to Employee]

B. Employee Information – *Must be completed by the employee.*

Social Security Number	Last Name, First Name, M.I. , ,	Job Title	
Home Address	Apt. No.	City, State ,	ZIP Code
Work Address		City, State ,	ZIP Code
Home Telephone ( ) -	Work Telephone ( ) -	No. of Hours Worked Per Week	Number of Dependents (including Spouse/ Domestic Partner)

Salary $	☐ Hourly ☐ Weekly ☐ Monthly	Marital Status ☐ Married ☐ Single	Check One ☐ Full-Time ☐ Part-Time ☐ 1099 ☐ Retiree ☐ Seasonal ☐ Temporary ☐ Union ☐ COBRA

C. Individuals Covered - ***List individuals for whom you are enrolling or adding/changing/removing coverage. Insert additional sheets if necessary.*** **NOTE FOR MEDICAL AND DENTAL COVERAGE:** While the Federal Patient Protection and Affordable Care Act mandates coverage of dependent children up to age 26, your plan may allow coverage beyond age 26. Some exceptions apply. Please refer to your plan documents or contact your benefits administrator.

If any person has used tobacco products (cigarettes, pipe, cigars, snuff, or chewing tobacco) an average of four or more times per week within the past six months, ✓ check below. Religious or ceremonial uses of tobacco (for example, by American Indians and Alaska Natives) are exempt. This only applies to enrolling person(s) that meet or exceed the state-defined legal tobacco age.

1	(A)dd (C)hange ___ (R)emove	**Employee Name** (Last, First, M.I.) , ,	Sex (M/F) ☐M ☐F	Social Security Number	Birthdate (MM/DD/YYYY) / /
Coverage Election ☐ Medical ☐ Dental ☐ Life/Disability		Primary Office ID Number (if applicable)	Current Patient **Yes** ☐	Dentist Office ID Number (if applicable)	Current Patient **Yes** ☐
Tobacco Use ☐ Yes ☐ No		Currently participating in Quit Smoking Program ☐ Yes ☐ No			

2	(A)dd (C)hange ___ (R)emove	**Name** (Last, First, M.I.) ☐ **Spouse** ☐ **Domestic Partner**	Sex (M/F) ☐M ☐F	Social Security Number	Birthdate (MM/DD/YYYY) / /
Coverage Election ☐ Medical ☐ Dental ☐ Life		Primary Office ID Number (if applicable)	Current Patient **Yes** ☐	Dentist Office ID Number (if applicable)	Current Patient **Yes** ☐
Tobacco Use ☐ Yes ☐ No		Currently participating in Quit Smoking Program ☐ Yes ☐ No			

3	(A)dd (C)hange ___ (R)emove	**Name** (Last, First, M.I.) ☐ **Child** ☐ **Stepchild** ☐ **Other**	Sex (M/F) ☐M ☐F	Social Security Number	Birthdate (MM/DD/YYYY) / /
Coverage Election ☐ Medical ☐ Dental ☐ Life		Primary Office ID Number (if applicable)	Current Patient **Yes** ☐	Dentist Office ID Number (if applicable)	Current Patient **Yes** ☐
Tobacco Use ☐ Yes ☐ No		Currently participating in Quit Smoking Program ☐ Yes ☐ No		Incapacitated ☐ Yes ☐ No	

4	(A)dd (C)hange ___ (R)emove	**Name** (Last, First, M.I.) ☐ **Child** ☐ **Stepchild** ☐ **Other**	Sex (M/F) ☐M ☐F	Social Security Number	Birthdate (MM/DD/YYYY) / /
Coverage Election ☐ Medical ☐ Dental ☐ Life		Primary Office ID Number (if applicable)	Current Patient **Yes** ☐	Dentist Office ID Number (if applicable)	Current Patient **Yes** ☐
Tobacco Use ☐ Yes ☐ No		Currently participating in Quit Smoking Program ☐ Yes ☐ No		Incapacitated ☐ Yes ☐ No	

5	(A)dd (C)hange ___ (R)emove	**Name** (Last, First, M.I.) ☐ **Child** ☐ **Stepchild** ☐ **Other**	Sex (M/F) ☐M ☐F	Social Security Number	Birthdate (MM/DD/YYYY) / /
Coverage Election ☐ Medical ☐ Dental ☐ Life		Primary Office ID Number (if applicable)	Current Patient **Yes** ☐	Dentist Office ID Number (if applicable)	Current Patient **Yes** ☐
Tobacco Use ☐ Yes ☐ No		Currently participating in Quit Smoking Program ☐ Yes ☐ No		Incapacitated ☐ Yes ☐ No	

D. Dependent Information

List any dependent in Section **C** living at another address.

Name	Address

For Dependent Life: If age 19 and over and a full-time student, provide the following:

Child Name	School Name	Expected Graduation Date	Number of Credit Hours

E. Coordination of Benefits

Will you have other health insurance at the same time as this coverage? ☐ Yes ☐ No

Name of Person	Carrier Name	Name of Person	Carrier Name

F. Declination/Waiver of Coverage - *Check all that apply*

I understand I am eligible to apply for this coverage through my employer; however, I am waiving coverage as noted below.

☐ **Employee:**
☐ Medical ☐ Dental ☐ Life ☐ Disability

☐ **Spouse/Domestic Partner:**
☐ Medical ☐ Dental ☐ Life

☐ **Child(ren):**
☐ Medical ☐ Dental ☐ Life

Reason for declining coverage

☐ Spouse/Domestic Partner group coverage
☐ Parental group coverage
☐ Medicare
☐ Medicaid
☐ Retiree coverage
☐ Another group plan provided by my employer
☐ COBRA coverage
☐ Insurance through another job
☐ TRICARE Military coverage
☐ Individual coverage – On or Off Exchange
☐ Do not want
☐ Other _____

I certify I have been given the right to apply for this coverage; however, I am waiving coverage as noted above. 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.

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

X Employee Signature

Date (Month/Day/Year)

Disclosure Acknowledgment

I understand that I am enrolling in a health care plan issued by Aetna Health Inc. or Aetna Life Insurance Company ("Aetna") that requires health care services be provided by participating providers. Failure to use a participating provider will result in reduced coverage or no coverage for services that I receive, and I will be fully responsible for any and all costs not covered by Aetna.

I received a list of participating providers. I may verify the participation status of a provider by using DocFind® at Aetna's web site, http://www.aetna.com. DocFind is updated weekly and can also be used to select a provider based on name, geographic location, group practice, medical specialty and/or hospital affiliation. I may also verify provider status by contacting Member Services at the number listed on my member ID card. I understand that the participation status of any provider may change from time to time and that it is my responsibility to verify participation of my health care provider with Aetna prior to receiving services.

As required by the State of Georgia regulations, the following is a summary of the financial arrangements with health care providers who are participating in the Aetna Health Inc. network:

1. Hospital providers are paid according to a contract that includes inpatient per diems, case rates, and discounted fee for service arrangements depending on the specific services provided.
2. Physicians are paid either a discounted fee for service in accordance with a specific fee schedule or a predetermined set amount per member per month (capitation).
3. Laboratory services are provided through a capitation arrangement (a per member per month flat fee).
4. Other ancillary services including home health, skilled nursing, and hospice are paid on a contracted fee schedule with per diems or per visit amounts, or through a capitated per member per month flat fee.

Conditions of Enrollment

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

1. I acknowledge that by enrolling in the following plans, coverage is provided by the following entities (collectively referred to as "Aetna"):
   - HNOnly (HMO OA) plans: Aetna Health Inc.
   - Life, Accidental Death & Personal Loss, disability, dental (except DMO®), PPO, Managed Choice Open Access, Indemnity and all other coverages: Aetna Life Insurance Company. DMO® dental coverage is provided by Aetna Health Inc.
2. I understand and agree that my employer's application will determine coverage and that there is no coverage unless and until both this enrollment form and the employer application have been accepted by Aetna. Even if this enrollment form is accepted, any intentional and material misstatements or omissions may result in future claims being denied and my coverage under the policy being rescinded or reevaluated, as of the effective date, for eligibility and rating purposes.

   For life and disability coverages: I understand that the effective date of insurance for myself or for any of my dependents is subject to my being actively at work on that date and that the effective date of insurance for any of my dependents is also subject to the dependent health condition requirements of the benefit plan. Further, I understand that any insurance subject to evidence of good health or medical information will not become effective until Aetna gives its written consent. For Dependent Life 10 to 50 Group Size, dependents are eligible from 14 days of age up to their 19th birthday, or up to their 23rd birthday, if a full-time student.

continued on next page

Conditions of Enrollment *(Continued)*

3. I understand and agree that this Enrollment/Change Form 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"), including pharmacies or pharmacy database benefit managers to give Aetna or its agent information concerning the medical history, prescription utilization history, services or treatment provided to anyone listed on this Enrollment/Change 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/domestic partner 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.
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® and Aetna Specialty Pharmacy, LLC, all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC and Aetna Specialty Pharmacy, LLC are subsidiaries 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.
6. I understand and agree that, with certain exceptions described in the plan documents, HMO and DMO® plans only provide coverage for referred benefits, and that, in order to be covered, services must be performed either by a participating primary care physician, primary care dentist, or by the participating specialist, hospital, pharmacy, dentist, or other provider as authorized by a referral from a participating primary care physician.

Misrepresentation

7. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any person who knowingly and with intent to defraud any insurance company or other person files an enrollment form 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.

I represent that all information supplied in this form is true and complete. I have read and agree to the Conditions of Enrollment and Misrepresentation on this **Georgia** Employee Enrollment/Change Form. I understand that, in the event I fail to sign this form within 31 days of my eligibility date or 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.

I am employed by the employer shown on Page 1, and I am working full time at least 25 hours per week for this employer at the regular place of business.

I have read and understand the information provided in the Disclosure section of this form.

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

Print&Submit Reset