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 that pages 2 and 3 are not visible.

Aetna®

Texas Employee Enrollment/Change Form

Large Employer: 51 or more employees
Small Employer: 2 – 50 employees

Social Security Number
313808849

Employer Name
Lintrac Services, Inc.

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 G.**

Effective Date
Date of Hire

- ☐ New Hire
- ☐ Rehire/Reinstatement
- ☐ New Group Enrollment
- ☐ Late Enrollment
- ☐ Other _____

- ☐ Change of coverage
- ☐ Add Spouse/Domestic Partner/ Dependent Child
- ☐ Name Change
- ☐ Other _____

- ☐ Employee Termination
- ☐ Remove Spouse/ Domestic Partner/ Dependent Child
- ☐ Cancel Coverage

COBRA/State Continuation for:
☐ Employee ☐ Dependent
Length of Continuation:
☐ 18 ☐ 36 ☐ Other _____
Original Qualifying Event Date _____
Reason _____

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 - *Check one.*
- ☐ Aetna HMO Plan – Plan _____
- ☐ Aetna OA MC Plan – Plan _____
- ☐ Aetna HNOption Plan – Plan _____
- ☐ Aetna HNOnly Plan – Plan _____
- ☐ Aetna Savings Plus Plan – Plan _____
- ☐ Aetna PPO Plan – Plan _____
- ☐ Aetna Indemnity Plan

Control/Group No.	Suffix	Account	Plan No.

2. Dental - *To enroll, enter plan number and name elected below.*
Standard Plan:
Plan Number: _____
Plan Name: _____
If FOC Option, check: ☐ DMO® *or* ☐ PDN
Voluntary Plans:
Plan Number: _____
Plan Name: _____
If FOC Option, check: ☐ DMO® *or* ☐ PDN
Out-of-State PDN Plans:
Plan Name: _____
Before today, were you covered under this employer's dental plan? ☐ Yes ☐ No

Control/Group No.	Suffix	Account	Plan No.

3. Life and Disability
- ☐ Basic Life/AD&D Ultra®
- ☐ Optional Dependent Life
- ☐ Life & Disability Packaged Plan

Beneficiary Designation - **Full Name** (First, Middle, Last)
Beneficiary Social Security Number
Relationship to Employee

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

Member ID Number (If Available)	Last Name, First Name, M.I.	Job Title	Home Telephone
	marcia j. gray.	office manager	(770) 506-6822

Home Address	Apt. No.	City, State	ZIP Code
113 windsor circle		stockbridge GA	30281

Work Address	City, State	ZIP Code	Work Telephone
3596 moreland ave	conley GA	30288	(404) 366-2247

Salary	No. of Hours Usually Worked Per Week	Check One	Marital Status	No. of Dependents Including Spouse/ Domestic Partner
$ ☐ Hourly ☐ Weekly ☐ Monthly		☐ Full-Time ☐ Part-Time ☐ 1099 ☐ Retiree ☐ Union ☐ COBRA ☐ Seasonal ☐ Temporary	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated	

Subscriber Primary Language (other than English) **Primer Idioma del suscriptor (que no sea el Ingles)**
What is your primary Language?
¿Cuál es su primer idioma? _____

Subscriber Disability
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. Individuals Covered - *List individuals for whom you are enrolling or adding/changing/removing coverage. Insert additional sheets if necessary.*

NOTE: Enter Domestic Partner ONLY if your employer has elected that coverage.

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.

(A)dd (C)hange (R)emove	Name (Last, First, M.I.)	Sex M/F	Social Security Number	Birthdate (MM/DD/YYYY)	Incapacitated	Coverage Election	Other Health Coverage	Other Dental Coverage	Child less than 25 years of age (Life/AD&D only)	Primary Office ID Number (if applicable)	Current Patient	Dental Office ID Number (if applicable)	Current Patient
	Employee 1. marcia j. gray.		313808849	07 12 1963	Yes N/A	☐ Medical ☐ Dental ☐ Life/Dis	Yes ☐	Yes ☐	Yes N/A		Yes ☐		Yes ☐
	☐ Spouse ☐ Domestic Partner 2.				N/A	☐ Medical ☐ Dental ☐ Life	☐	☐	N/A		☐		☐
	☐ Child ☐ Stepchild ☐ Other 3.				☐	☐ Medical ☐ Dental ☐ Life	☐	☐	☐		☐		☐
	☐ Child ☐ Stepchild ☐ Other 4.				☐	☐ Medical ☐ Dental ☐ Life	☐	☐	☐		☐		☐
	☐ Child ☐ Stepchild ☐ Other 5.				☐	☐ Medical ☐ Dental ☐ Life	☐	☐	☐		☐		☐
	☐ Child ☐ Stepchild ☐ Other 6.				☐	☐ Medical ☐ Dental ☐ Life	☐	☐	☐		☐		☐

Social Security Number
313808849

D. Dependent Information

List any dependent in Section C living at another address.	Name:	Reason:	Address:
If any dependent's last name differs from yours, explain.	Name:	Reason:	

FOR DEPENDENT LIFE: If age +19 and a full-time student, provide the following:

Child Name	School Name	Expected Graduation Date	Number of Credit Hours

E. Race/Ethnicity – Optional (This information is designed for the purpose of data collection and 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 _____

Spouse/Domestic Partner
2. ☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____

Child/Stepchild/Other
3. ☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____

Child/Stepchild/Other
4. ☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____

Child/Stepchild/Other
5. ☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____

Child/Stepchild/Other
6. ☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____

F. Other Insurance

If you have checked "Yes" to Other **Health** Coverage (Section C), provide name and policy number of insurance carrier, HMO, or other source, a copy of the insurance card, and start date of the coverage.

If you have checked "Yes" to Other **Dental** Coverage (Section C), provide name and policy number of insurance carrier, HMO, or other source, a copy of the insurance card, and start date of the coverage.

Is your Spouse/Domestic Partner employed? ☐ Yes ☐ No If Yes, provide name and address of spouse/domestic partner's employer.

PROOF OF PRIOR COVERAGE – IMPORTANT *(Required)*

Does anyone age 19 and over enrolling on this enrollment form have prior medical coverage? If Yes, provide the information requested in the table below.

Proof of coverage should accompany this enrollment form for pre-existing condition credit if enrolling in other than an HMO plan.

Acceptable forms of proof are:
1. Certificate of Creditable Coverage from prior carrier, or
2. Copy of ID card or most recent payroll stub showing medical coverage deduction, or
3. Copy of most recent medical premium bill from prior carrier.

Failure to provide Proof of Prior Coverage may subject you or a family member (age 19 and over) to the full pre-existing conditions limitation with no credit for prior coverage if enrolling in other than an HMO plan. You may request a Certificate of Creditable Coverage from your prior carrier. **NOTE:** If your Plan contains a pre-existing conditions provision, the pre-existing conditions exclusion and limitation will not apply to a person under 19 years of age.

Name of Covered Individual	Carrier Name	Group Number	Start Date	Termination Date	Health
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

G. Declination/Waiver of Coverage - *To be completed if medical and/or dental coverage is declined or refused by an eligible employee and/or their eligible family members.*

1. **Medical Coverage Declined for:**
   ☐ Myself ☐ Dependents ☐ Spouse/Domestic Partner
2. **Dental Coverage Declined for:**
   ☐ Myself ☐ Dependents ☐ Spouse/Domestic Partner

Reason for Declining Coverage *(If applicable, please attach front/back of your health coverage ID card.)*:
☐ Spousal/Domestic Partner group coverage ☐ COBRA coverage
☐ Medicare ☐ TRICARE or CHAMPVA
☐ Medicaid ☐ Another group plan provided by my employer
☐ Individual coverage ☐ Do not want
☐ Retiree coverage ☐ 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 myself and/or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage. Pre-existing conditions, when enrolled in other than an HMO plan, may not be covered for twelve months. **NOTE:** If your Plan contains a pre-existing conditions provision, the pre-existing conditions exclusion and limitation will not apply to a person under 19 years of age.

Please sign here ONLY if you are declining coverage for yourself or dependent(s).	***Date (Month/Day/Year)***
X Employee Signature	

H. Health Questionnaire for Groups Enrolling 2 – 50 or 51+ Eligible Employees (and employees of groups enrolling for Life coverage greater than the Guaranteed Issue Level)

Health History for Employees and your Dependents. ***The following information is confidential and will not be seen by or given to your employer.***

- ALL of the questions must be answered by you or your dependents or the enrollment form will be returned.
- Incomplete enrollment forms may delay the effective date of your coverage.

List all individuals enrolling for coverage. Name	Sex	Age	Height	Weight	Smoker	Currently Taking Prescription Medication(s)
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No

Answer all the questions.

1. Within the last 5 years has anyone applying for coverage consulted, received treatment, by a doctor, psychiatrist, psychologist, or other practitioner or been diagnosed with any of the following conditions or disorders? (Check all that apply.) ☐ Yes ☐ No

a. ☐ Diabetes
b. ☐ Infertility
c. ☐ Endocrine/Metabolic
d. ☐ Pancreas
e. ☐ Liver/Hepatitis
f. ☐ Immune System
g. ☐ Blood Disorder
h. ☐ Epilepsy/Seizure
i. ☐ Heart
j. ☐ Paralysis/Paresis
k. ☐ Tumor/Cyst/Growth
l. ☐ Systemic or Discoid Lupus
m. ☐ Lung or Respiratory
n. ☐ Alcohol or Drug Use
o. ☐ Kidney/Bladder/Urinary
p. ☐ Circulatory/Vascular
q. ☐ Digestive/Stomach/Intestinal
r. ☐ Central Nervous System
s. ☐ Pituitary/Adrenal/Growth Disorder
t. ☐ Birth Defects/Congenital Abnormalities
u. ☐ Arthritis/Bone/Joint/Muscle/Prosthetic Device
v. ☐ Mental/Nervous/Emotional/Eating Disorder
w. ☐ Stroke/Brain/Neurological
x. ☐ Transplant: ☐ Recommended ☐ Pending ☐ Complete
y. ☐ Advised to have surgery or course of treatment not yet determined
z. ☐ Cancer: Type: _____ Stage _____ ☐ Surgery ☐ Chemo ☐ Radiation
aa. ☐ Using: ☐ Crutches ☐ Walker ☐ Wheelchair
bb. ☐ Other _____

2. Has anyone applying for coverage ever been diagnosed as having or been told by a medical doctor that they have AIDS, HIV or an ARC disorder? ☐ Yes ☐ No

3. Is any female currently pregnant? If so, provide due date _____ Check applicable boxes: ☐ C section planned ☐ Multiple Births Expected (# _____) ☐ Complications: ☐ Past or ☐ Present ☐ Yes ☐ No

4. Has anyone applying for coverage incurred medical expenses in excess of $5,000 in the past 24 months? ☐ Yes ☐ No

5. Has anyone applying for coverage been prescribed medications in the past 12 months? ☐ Yes ☐ No

6. Does anyone applying for coverage have a known condition that requires on-going treatment? ☐ Yes ☐ No

7. Do you or your spouse use tobacco products? If so, check the applicable boxes:
☐ Employee: ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Chewing Tobacco
☐ Spouse: ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Chewing Tobacco
☐ Yes ☐ No

Provide details below to any boxes checked above. ***(If additional space is needed, attach a separate sheet and be sure to sign and date the sheet.)***

Question Number	Name of Individual	Condition/Diagnosis/Treatment	Date of Onset	Date Treatment Ended	Names of Prescription Medication(s)	Dosage	Still Taking Medication
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

If you are providing additional sheets, check here ☐ *and insert the sheets before sealing this Enrollment form.*

Conditions of Enrollment

On behalf of myself and the dependents listed on the reverse side, 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"):
   - Aetna HMO Plan and Aetna HNOnly Plan: Aetna Health Inc.
   - Aetna HNOption Plans: Aetna Health Inc. (In-Network) and Aetna Health Insurance Company, (Out-of-Network)
   - Aetna Dental DMO: Aetna Dental Inc.
   - Life, disability, dental and all other health coverages: Aetna Life Insurance Company.
2. I understand and agree that my employer's application will determine coverage and that there is no coverage unless and until both the eligible employee and employer applications have been accepted by Aetna. Even if this enrollment form is accepted, any intentional misstatement or omission of material fact may result in future claims being denied.

   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.
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"), to give to Aetna or its agent information concerning the medical history, services or treatment provided to anyone listed on this Enrollment/Change Form, including those involving mental health and substance abuse. 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®, 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.
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.
7. I understand and agree that, as described in the plan documents, when enrolled for medical coverage in other than an HMO plan, any pre-existing conditions for my spouse/domestic partner, dependents or myself may not be covered for 12 months. **NOTE:** If your Plan contains a pre-existing conditions provision, the pre-existing conditions exclusion and limitation will not apply to a person under 19 years of age.

Misrepresentation

8. 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 intentional misrepresentation of material fact or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which may be a crime and may subject 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 **Texas** Employee Enrollment/Change Form. I understand that, in the event I fail to sign this form within 31 days after the above transaction request 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, usually 30 hours per week, for this employer at the regular place of business.

If you have questions concerning the benefits and services that are provided by or excluded under this Agreement, please contact a Member Services representative at 1-800-323-9930 before signing this form.

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

Print & Submit Reset