

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.



Illinois Small Group Business (2 - 50 Eligible Employees) Employee Enrollment/Change Form

Group Number
Social Security Number

Company Name		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 C.			
Effective Date	<input type="checkbox"/> New Hire <input type="checkbox"/> Rehire/Reinstatement	<input type="checkbox"/> Change of coverage <input type="checkbox"/> Add Spouse/ Dependent Child	<input type="checkbox"/> Employee Termination <input type="checkbox"/> Remove Spouse/ Dependent Child	COBRA/State Continuation for: <input type="checkbox"/> Employee <input type="checkbox"/> Dependent	
Date of Hire	<input type="checkbox"/> New Group Enrollment <input type="checkbox"/> Late Enrollment <input type="checkbox"/> Other _____	<input type="checkbox"/> Name Change <input type="checkbox"/> Other _____	<input type="checkbox"/> Cancel Coverage	Length of Continuation: <input type="checkbox"/> 18 <input type="checkbox"/> 36 <input type="checkbox"/> Other _____	
				Original Qualifying Event Date _____	

A. Coverage Selection – Please print clearly, using black ink.

Control/Group No.	Suffix	Account	Plan No.	Class Code	Control/Group No.	Suffix	Account	Plan No.	Control/Group No.	Suffix	Account	Plan No.		
1. Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Check applicable boxes. <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) Check one: <input type="checkbox"/> Managed Choice® (Open Access) Plan – Plan Option: _____ <input type="checkbox"/> Open Choice® PPO Plan – Plan Option: _____ <input type="checkbox"/> Indemnity Plan – Plan Option: _____ <input type="checkbox"/> Out-of-State PPO Plan – Plan Option: _____ <input type="checkbox"/> Other Plan – Plan Option: _____					2. Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No Check applicable boxes. <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) Check one: Standard Plans: <input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2 <input type="checkbox"/> Option 3: <input type="checkbox"/> DMO® or <input type="checkbox"/> PPO <input type="checkbox"/> Option 4 <input type="checkbox"/> Option 5 <input type="checkbox"/> Option 6 <input type="checkbox"/> Option 7 <input type="checkbox"/> Out-of-State PPO Voluntary Plans: <input type="checkbox"/> Option V1 <input type="checkbox"/> Option V2 <input type="checkbox"/> DMO® or <input type="checkbox"/> PPO <input type="checkbox"/> Option V3 <input type="checkbox"/> Out-of-State PPO Before today, were you covered under this employer's dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No					3. Life and Disability: <input type="checkbox"/> Yes <input type="checkbox"/> No Check applicable boxes. <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) Check one: <input type="checkbox"/> Basic Life/AD&D Ultra™ <input type="checkbox"/> Optional Dependent Life <input type="checkbox"/> Short Term Disability <input type="checkbox"/> 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 Aetna ID Number (if available)	Last Name, First Name, M.I.	Job Title	Home Telephone	Primary Language Spoken (Optional)		
Home Address		Apt. No.	City, State		ZIP Code	
Work Address		City, State		ZIP Code	Work Telephone	
Salary \$	<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	Number of Hours Worked Per Week	Check One <input type="checkbox"/> Full-Time <input type="checkbox"/> 1099 <input type="checkbox"/> Seasonal <input type="checkbox"/> Part-Time <input type="checkbox"/> Retiree <input type="checkbox"/> Temporary		Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single	Number of Dependents Including Spouse

C. 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.

<input type="checkbox"/> Employee	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Life	<input type="checkbox"/> Disability	Reason for declining coverage (If applicable attach front/back of your health ID card): <input type="checkbox"/> Covered by spouse's group coverage - Carrier Name and ID number: _____ <input type="checkbox"/> Enrolled in other insurance (check applicable box): <input type="checkbox"/> Medicare <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> Military <input type="checkbox"/> Individual <input type="checkbox"/> COBRA <input type="checkbox"/> Retiree <input type="checkbox"/> Other _____ <input type="checkbox"/> Carrier Name and ID number: _____ <input type="checkbox"/> Spouse covered by employer's group coverage <input type="checkbox"/> Do Not Want
<input type="checkbox"/> Spouse	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Life		
<input type="checkbox"/> Child(ren)	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Life		

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 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 this plan, may not be covered for **twelve months**.

Sign here ONLY if you are declining coverage for yourself and/or dependent(s). X Employee Signature	Date (Month/Day/Year)
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D. Individuals Covered - List individuals for whom you are enrolling or adding/changing/removing coverage. Insert additional sheets if necessary.

1. Employee Name (Last, First, M.I.)				Sex (M/F)	Social Security Number		
Birthdate (MM/DD/YYYY)	Height (ft, in)	Weight (lbs)	Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated	Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life/Disability		PCP Provider ID Number	Current Patient Yes <input type="checkbox"/>
2. Spouse Name (Last, First, M.I.)				Sex (M/F)	Social Security Number		Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____
Birthdate (MM/DD/YYYY)	Height (ft, in)	Weight (lbs)	Status <input type="checkbox"/> Different Last Name	Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life		PCP Provider ID Number	Current Patient Yes <input type="checkbox"/>
3. Child Name (Last, First, M.I.)				Sex (M/F)	Social Security Number		Relationship <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____
Birthdate (MM/DD/YYYY)	Height (ft, in)	Weight (lbs)	Status <input type="checkbox"/> Different Last Name <input type="checkbox"/> Lives at another address <input type="checkbox"/> Full-Time Student (19+) <input type="checkbox"/> Disabled (19+)	Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life		PCP Provider ID Number	Current Patient Yes <input type="checkbox"/>
4. Child Name (Last, First, M.I.)				Sex (M/F)	Social Security Number		Relationship <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____
Birthdate (MM/DD/YYYY)	Height (ft, in)	Weight (lbs)	Status <input type="checkbox"/> Different Last Name <input type="checkbox"/> Lives at another address <input type="checkbox"/> Full-Time Student (19+) <input type="checkbox"/> Disabled (19+)	Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life		PCP Provider ID Number	Current Patient Yes <input type="checkbox"/>

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. <input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02 <input type="checkbox"/> Hispanic or Latino – 03 <input type="checkbox"/> Asian – 04 <input type="checkbox"/> Other – 05 _____	Child 3. <input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02 <input type="checkbox"/> Hispanic or Latino – 03 <input type="checkbox"/> Asian – 04 <input type="checkbox"/> Other – 05 _____
Spouse 2. <input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02 <input type="checkbox"/> Hispanic or Latino – 03 <input type="checkbox"/> Asian – 04 <input type="checkbox"/> Other – 05 _____	Child 4. <input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02 <input type="checkbox"/> Hispanic or Latino – 03 <input type="checkbox"/> Asian – 04 <input type="checkbox"/> Other – 05 _____

F. Dependent Information

List any dependent in Section D living at another address.	Name:	Reason:	Address:
If any dependent's last name differs from yours, explain.	Name:	Reason:	
If age 19+ and a full-time student, provide the following:			
Child Name	School Name	Expected Graduation Date	Number of Credit Hours

G. Other Insurance

Does anyone enrolling on this enrollment form have current or prior coverage? Yes No

Proof of coverage must accompany this enrollment form for pre-existing condition credit and if an employee is waiving coverage. 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 to the full pre-existing conditions limitation with no credit for prior coverage. You may request a Certificate of Creditable Coverage from your prior carrier.

Name of Covered Individual	Carrier Name	Group Number	Start Date	Termination Date	Health
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

H. Medicare Information

Name of Person	Medicare Part A	Medicare Part B	Medicare Part D	Over Age 65	Disability	End-Stage Renal Disease Effective Date
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

I. Health Questionnaire for Groups Enrolling 2 - 19 Eligible Employees

Health History for Individuals and Their 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 and your dependents or the enrollment form will be returned.
- Incomplete enrollment forms may delay the effective date of your coverage.

In the past five (5) years, has any person listed on the enrollment form seen a health care provider(s), had treatment recommended, received treatment, including prescription medications or been hospitalized for any of the following conditions listed below?	Yes	No
1. Heart attack, heart murmur, stroke, chest pain, high blood pressure, anemia, varicose veins or other disorders of the heart, blood, blood vessels or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>
2. Ulcer, colitis, gallstones or any other disorder of the stomach, intestines, rectum, pancreas, liver or Hepatitis B/C?	<input type="checkbox"/>	<input type="checkbox"/>
3. Cancer, cyst or tumor?	<input type="checkbox"/>	<input type="checkbox"/>
4. Disorders of the kidneys, adrenal glands, thyroid gland, urinary system, male or female organs, infertility, menstrual dysfunction or sexually-transmitted disease (except AIDS/ARC)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Asthma, emphysema, tuberculosis or any other disorders of the lungs or respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>
6. Migraines, fainting spells, epilepsy, mental or nervous conditions, depression, paralysis or any disorder of the brain or nervous system? If epileptic, date of last seizure: ____/____/____ (month/day/year)	<input type="checkbox"/>	<input type="checkbox"/>
7. Lupus, arthritis, back trouble or any other disorder of the joints, muscles or bones, including prosthetic device or implants?	<input type="checkbox"/>	<input type="checkbox"/>
8. Any physical deformity, defect or congenital problem?	<input type="checkbox"/>	<input type="checkbox"/>
9. Told by a physician they have an immune disorder?	<input type="checkbox"/>	<input type="checkbox"/>
10. Diagnosed or treated by a physician for AIDS or AIDS-Related Complex?	<input type="checkbox"/>	<input type="checkbox"/>
11. Treated by a physician for alcoholism, other drug or substance abuse, including use of any illegal or controlled drugs, or been advised by a physician to seek treatment for the same?	<input type="checkbox"/>	<input type="checkbox"/>
12. Diagnosed with diabetes by a physician? If Yes, list date of diagnosis: ____/____/____ (month/day/year) <input type="checkbox"/> Insulin dependent <input type="checkbox"/> Non-insulin dependent.....	<input type="checkbox"/>	<input type="checkbox"/>
13. a. Is any female to be covered currently pregnant? If Yes, list due date: ____/____/____ (month/day/year)	<input type="checkbox"/>	<input type="checkbox"/>
b. Have there been any complications thus far?	<input type="checkbox"/>	<input type="checkbox"/>
c. Are multiple births expected?	<input type="checkbox"/>	<input type="checkbox"/>
d. If you are a male listed on this enrollment form, are you expecting a child with anyone, even if the mother is not listed on this enrollment form?	<input type="checkbox"/>	<input type="checkbox"/>
14. Taken any prescribed medications in the past 12 months? If Yes, list on the following page.	<input type="checkbox"/>	<input type="checkbox"/>
15. Had an abnormal physical exam or been advised by a physician to undergo further testing, surgery or treatment?	<input type="checkbox"/>	<input type="checkbox"/>
16. Been a patient in a hospital, clinic, surgical center, sanatorium or medical facility as an outpatient or inpatient (excluding childbirth)?	<input type="checkbox"/>	<input type="checkbox"/>
17. Does anyone listed on this enrollment form use tobacco products? If Yes, check applicable boxes. <input type="checkbox"/> Employee: <input type="checkbox"/> Cigarettes <input type="checkbox"/> pipe <input type="checkbox"/> cigars <input type="checkbox"/> chewing tobacco	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Spouse: <input type="checkbox"/> Cigarettes <input type="checkbox"/> pipe <input type="checkbox"/> cigars <input type="checkbox"/> chewing tobacco	<input type="checkbox"/>	<input type="checkbox"/>
18. Has any person had any medical condition or symptom not listed on this enrollment form?	<input type="checkbox"/>	<input type="checkbox"/>

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS ABOVE, YOU MUST COMPLETE SECTION K ON THE FOLLOWING PAGE.

J. Health Questionnaire for Groups Enrolling 20 – 50 Employees

Health History for Individuals and Their 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 and your dependents or the application will be returned.
- Incomplete applications may delay the effective date of your coverage.

In the past five (5) years, have you, your spouse or any of your dependents:	Yes	No
1. Had, consulted for by a physician, had treatment rendered by a physician, been advised to have treatment by a physician or been hospitalized for any of the following by a physician: Cardiovascular disease or heart attack, stroke; disorder of the kidneys, stomach, intestines or liver; musculoskeletal conditions; mental or nervous condition; central nervous system disorder; diabetes; any disorder of the lungs or respiratory system; or cancer?	<input type="checkbox"/>	<input type="checkbox"/>
2. Had or been told by a physician they have an immune disorder?	<input type="checkbox"/>	<input type="checkbox"/>
3. Been diagnosed or treated by a physician for AIDS or AIDS-Related Complex?	<input type="checkbox"/>	<input type="checkbox"/>
4. Visited a healthcare professional for any illness and/or medical condition resulting in medical expenses of more than \$5,000 in the past 24 months?	<input type="checkbox"/>	<input type="checkbox"/>
5. Been advised by a physician in the last 12 months that hospitalization, surgery or treatment is needed or pending?	<input type="checkbox"/>	<input type="checkbox"/>
6. a. Is any female to be covered currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
b. If you are a male listed on this enrollment form, are you expecting a child with anyone, even if the mother is not listed on this enrollment form?	<input type="checkbox"/>	<input type="checkbox"/>
7. Does anyone listed on this enrollment form use tobacco products? If Yes, check applicable boxes. <input type="checkbox"/> Employee: <input type="checkbox"/> Cigarettes <input type="checkbox"/> pipe <input type="checkbox"/> cigars <input type="checkbox"/> chewing tobacco	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Spouse: <input type="checkbox"/> Cigarettes <input type="checkbox"/> pipe <input type="checkbox"/> cigars <input type="checkbox"/> chewing tobacco	<input type="checkbox"/>	<input type="checkbox"/>

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS ABOVE YOU MUST COMPLETE SECTION K ON THE FOLLOWING PAGE.

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

K. Health Questionnaire - Details for "Yes" Responses in Sections I and J.

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS IN SECTIONS I and J YOU MUST COMPLETE THE FOLLOWING.
 Please provide us with FULL DETAILS for each "Yes" answer to any condition(s) checked in Sections I and J. **In addition**, please give details below of last doctor visit and/or physical examination for **ALL** family members listed regardless of the date or reason. *(Insert additional sheets if necessary.)*

Ques. No.	Name of Individual	Condition/Diagnosis	Date of Onset	Date Treatment Ended	Medication Prescribed	Dosage	Still Taking Medication
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> 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:

- I acknowledge that by enrolling in the following plans, coverage is provided by the following entities (collectively referred to as "Aetna"):
 - Aetna HMO: Aetna Health of Illinois Inc.
 - Aetna POS: Aetna Health of Illinois Inc. and Aetna Health Insurance Company
 - Aetna Managed Choice (Open Access): Aetna Life Insurance Company
 - Life, Accidental Death & Dismemberment, disability, dental, Aetna PPO and all other coverages: Aetna Life Insurance Company.
- I understand and agree that my employer's enrollment form will determine coverage and that there is no coverage unless and until both the eligible employee and employer enrollment forms have been accepted and approved by Aetna. Even if this enrollment form is approved, any misstatements or omissions may result in future claims being denied and the policy or my coverage under the policy being rescinded or reevaluated, as of the effective date, for eligibility and rating purposes except as provided by law.
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.
- 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 to 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 and competent adult dependents, and I have obtained their consent to those terms. I understand 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 for 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.
- The plan documents will determine the rights and responsibilities of member(s) and will govern in the event of conflicts with any benefits comparison, summary or other description of the plan. Any direct conflict between this form and the plan documents will be resolved according to the terms which are most favorable to the member.
- 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.
- I understand and agree that, with certain exceptions described in the plan documents, HMO 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 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 the 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 on this form is true and complete. I have read and agree to the Conditions of Enrollment and Misrepresentation on this Illinois Small Group Business (2 - 50 Employees) 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.

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