Enrollment/Change Request
Aetna Life Insurance Company

Employer Group Information: (To Be Completed by Employer)

Employer Name - Full Name of Business or Organization	Control	Suffix	Account	Plan Number
ANDROSCOGGIN HOME HEALTHCARE + HOSPICE	0143513	31	002	201
Employer Address (Street, City, State, ZIP Code) - Primary Location of Business or Organization	**Group Number (IMO Only)**		**Customer Code (Optional)**	
15 STRAWBERRY AVE. LEWISTON, ME 04240				

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

Instructions: *Refer to the instructions on the back before completing this form. You, the employee, 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.*

Enrollment - *Check one.*
- ☑ New Enrollee/Subscriber — Effective Date: 02 / 01 / 2022 — 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 Admin.
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

Beneficiary Designation - **Full Beneficiary Name** (First, Middle, Last) If more than one beneficiary, use Special Remarks (Section D).	Social Security Number of Beneficiary	Relationship to Employee	Earnings	
			☐ Annually $ ____	☐ Insurance Amount $ ____
			☐ Weekly $ ____	☐ Supplemental Life $ ____
				☐ AD&D Amount $ ____

C. Plan Options - **Your selection must be offered by your employer.**

Check One:
- ☐ Aetna Choice® POS II
- ☐ Aetna HealthFund®
- ☐ Aetna Open Access® Elect Choice
- ☐ Aetna Open Access® Managed Choice
- ☐ Elect Choice® EPO
- ☐ Managed Choice® POS
- ☐ Open Choice® PPO
- ☐ Traditional Choice®
- ☑ Other DENTAL

While the Federal Patient Protection and Affordable Care Act generally mandates coverage of dependent children up to age 26, your plan may allow coverage beyond age 26. Please refer to your plan documents or contact your benefits administrator.

D. Individuals Covered - **List individuals for whom you are 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	Name (First, Middle Initial, Last) (Explain difference in last names in Special Remarks.)	Relation. Code	Sex M F	Birthdate MM DD YYYY	Social Security Number (If dependent has no SSN, write "None")	Prior Insur. Plan	Other Medical Coverage	Other Rx Drug Coverage	Handi-capped	Primary Medical Office ID Number	Current Patient
		Self	☐ ☐	/ /		Yes * ☐	Yes * ☐	Yes * ☐	Yes N/A		Yes ☐
			☐ ☐	/ /		☐	☐	☐	☐		☐
			☐ ☐	/ /		☐	☐	☐	☐		☐
			☐ ☐	/ /		☐	☐	☐	☐		☐

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.)

Code	Other

Using the KEY below, please identify the Race/Ethnicity code for each individual.

KEY:
- **01** - White
- **02** - African American or Black
- **03** - Hispanic or Latino
- **04** - Asian
- **05** - Other (Provide race/ethnicity in "Other" column at left)

1. If "Yes" to **Prior Insurance Plan** and/or **Other Medical Coverage** above, provide effective dates, name & policy number of insurance carrier, HMO or other source and your **Member Identification Number**.

2. If "Yes" to **Other Rx Drug Coverage** above, provide effective dates, name & policy number of insurance carrier, HMO or other source and your **Member Identification Number**.

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

Special Remarks

E. Employee/Spouse/Dependent Signatures

Misrepresentation: 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 or a denial of insurance benefits.

I certify that all information supplied in this form 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 reverse side of this Enrollment/Change Request form.

Employee Signature - *Required*	Date	Spouse Signature	Date	Dependent Signature *(if over 18)*	Date
X	/ /		/ /		/ /
E-Mail Address	**Primary Language Spoken**	**Dependent Signature** *(if over 18)*	**Date**	**Dependent Signature** *(if over 18)*	**Date**
			/ /		/ /

Instructions

Employer - Complete the **Employer Group Information** at the top of the form.

Employee - Complete Sections A - E.

Section A - Type of Activity:

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

Section B - Employee Information:

- Complete **all** information in order for your Enrollment/Change Request to be processed.
- Beneficiary Designation - Complete only if your employer is offering Aetna Life Insurance coverage.

Section C - Plan Options: Select only an option offered by your employer.

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 name(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
  - 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) were covered under your employer's or other **Prior Insurance Plan** or currently have **Other Medical Coverage**, check the "Yes" box(es) and provide beginning and ending effective dates, name and policy number of insurance carrier, HMO or other source and your **Member Identification Number** in the space provided in Number 1.
- If you or your dependent(s) have **Other Rx Drug Coverage**, check the "Yes" box and provide beginning and ending effective dates, name and policy number of insurance carrier, HMO or other source and your **Member Identification Number** in the space provided in Number 2.
  - **NOTE**: In some instances your medical carrier will differ from your Rx Drug carrier.
- If a dependent is Handicapped and financially dependent, check "Yes" and provide proof of handicapped status from the attending physician.
- Primary Medical Office ID Number - Locate the office ID number for the primary care physician from the appropriate provider directory or from "DocFind®", Aetna's online provider directory at "www.aetna.com".
- If you are a current patient, please check the "Yes" box under Current Patient.
- *Optional* - Using the KEY provided, please enter the Race/Ethnicity code for each individual. If your Race/Ethnicity is "Other," print the Race/Ethnicity for each individual in the space provided.

Section E - Employee/Spouse/Dependent Signatures:

- Complete this section for all new enrollments or coverage changes.
- Employee must sign and date the Enrollment/Change Request in order for it to be processed.
- When requesting coverage for spouse and/or dependents over age 18, spouse and/or dependent signatures are required.

Conditions of Enrollment

Applicant Acknowledgments and Agreements

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 an Aetna plan coverage is underwritten or administered by Aetna Life Insurance Company (referred to as "Aetna"). All statements herein shall be deemed representations and not written warranties.
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 authorize Aetna, its authorized employees, agents, consultants and designees, health care providers, third party payers, accreditation organizations and utilization review agencies, to exchange health care, medical, mental health, substance abuse, AIDS and HIV, and related insurance information, any of which relates to me, for purposes of claims payment and fraud prevention; preventive health, early detection and disease management programs; coordination of patient care; quality improvement/management/assessment; utilization review and management; fulfilling state and federal requirements; HEDIS and similar data collection and reporting; accreditation by the National Committee for Quality Assurance and other accreditation organizations; and statistical research. **This authorization excludes divulging whether tests for the presence of the HIV antibody have been performed and excludes divulging the results of such tests. Such tests shall not be disclosed or published. Nothing in this caveat will prohibit this authorization from divulging the fact that the applicant has AIDS/ARC.** 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. I give authorization for myself and any eligible family members listed on this application for whom I am authorized to do so. I understand that I may receive a copy of this form. I further understand that this authorization will be effective until coverage under this plan and any renewal thereof ends, unless I give written notice to Aetna that I want to revoke this authorization. I understand that my failure to agree to this authorization, or my revocation of this authorization, may impair the ability of Aetna to evaluate or process an application or claim and may be a basis for denying an application or claim for benefits.
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.