Dental Enrollment/Change Request
Aetna Life Insurance Company*

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

Employer group information – To be completed by employer.	**Control**	**Suffix**	**Account**	**Plan number**
	181163			

Employer name – full name of business or organization

State of Alaska - Political Subdivisions - Group Name:

Employer address (street, city, state, ZIP code) – primary location of business or organization

A. Type of activity – Employee completes sections A – E. *Please print clearly.*

Enrollment – *Check one.*
- ☐ New enrollee / subscriber

Effective date: ____/____/____

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 Administration

Date of loss of coverage: _____

Date of qualifying event: _____

Continuation of coverage expiration date: _____

B. Employee information

Social Security number	Last name, first name, middle initial		Home telephone ( ) -	Work telephone ( ) -
Employee status ☐ Active ☐ Retired	Employee home address	Apt. number	City, state	ZIP code

C. Plan options – *Check one.* Your selection must be offered by your employer.

☐ Indemnity Dental	☐ Dental EPP	☐ FOC / Indemnity
☐ DentalFund / HealthFund	☐ DMO® / Advantage / Basic	☐ FOC / PPO
☑ Dental PPO		☐ FOC / DMO®

D. Individuals covered – *List individuals for whom you are enrolling or 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 ___	**1. Employee name** - Last name, first name, middle initial					Relation code **Self**	Sex (M/F)	**Birthdate** (MM/DD/YYYY)
Social Security number	Late entrant **Yes** ☐	Prior insur. plan **Yes*** ☐	Other dental coverage **Yes*** ☐	Currently covered by Medicare **Yes*** ☐	Handi-capped **N/A**	Student **N/A**	Primary dentist office ID number	Current patient **Yes** ☐
(A)dd **(C)**hange **(R)**emove ___	**2. Spouse name** - Last name, first name, middle initial (Explain difference in last name in Special remarks.)					Relation code	Sex (M/F)	**Birthdate** (MM/DD/YYYY)
Social Security number (if dependent has no SSN, write "None")	Late entrant **Yes** ☐	Prior insur. plan **Yes*** ☐	Other dental coverage **Yes*** ☐	Currently covered by Medicare **Yes*** ☐	Handi-capped **Yes** ☐	Student **Yes** ☐	Primary dentist office ID number	Current patient **Yes** ☐

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D. Individuals covered ***(Continued) – List individuals for whom you are enrolling or adding / changing / removing coverage.***

**** Provide details for "Yes*" responses below.*** Attach sheet to list additional children.

(A)dd (C)hange (R)emove	3. **Child name** - Last name, first name, middle initial (Explain difference in last name in Special remarks.)	Relation code	Sex (M/F)	**Birthdate** (MM/DD/YYYY)

Social Security number (if dependent has no SSN, write "None")	Late entrant **Yes** ☐	Prior insur. plan **Yes*** ☐	Other dental coverage **Yes*** ☐	Currently covered by Medicare **Yes*** ☐	Handi-capped **Yes** ☐	Student **Yes** ☐	Primary dentist office ID number	Current patient **Yes** ☐

(A)dd (C)hange (R)emove	4. **Child name** - Last name, first name, middle initial (Explain difference in last name in Special remarks.)	Relation code	Sex (M/F)	**Birthdate** (MM/DD/YYYY)

Social Security number (if dependent has no SSN, write "None")	Late entrant **Yes** ☐	Prior insur. plan **Yes*** ☐	Other dental coverage **Yes*** ☐	Currently covered by Medicare **Yes*** ☐	Handi-capped **Yes** ☐	Student **Yes** ☐	Primary dentist office ID number	Current patient **Yes** ☐

(A)dd (C)hange (R)emove	5. **Child name** - Last name, first name, middle initial (Explain difference in last name in Special remarks.)	Relation code	Sex (M/F)	**Birthdate** (MM/DD/YYYY)

Social Security number (if dependent has no SSN, write "None")	Late entrant **Yes** ☐	Prior insur. plan **Yes*** ☐	Other dental coverage **Yes*** ☐	Currently covered by Medicare **Yes*** ☐	Handi-capped **Yes** ☐	Student **Yes** ☐	Primary dentist office ID number	Current patient **Yes** ☐

(A)dd (C)hange (R)emove	6. **Child name** - Last name, first name, middle initial (Explain difference in last name in Special remarks.)	Relation code	Sex (M/F)	**Birthdate** (MM/DD/YYYY)

Social Security number (if dependent has no SSN, write "None")	Late entrant **Yes** ☐	Prior insur. plan **Yes*** ☐	Other dental coverage **Yes*** ☐	Currently covered by Medicare **Yes*** ☐	Handi-capped **Yes** ☐	Student **Yes** ☐	Primary dentist office ID number	Current patient **Yes** ☐

1. If **yes** to **Prior insurance plan** and / or **Other medical coverage** above, provide effective dates, name and policy number of insurance carrier, HMO, or other source and your **member identification number**.

2. If **yes** to **Other dental coverage** and / or **Currently covered by Medicare** above, provide effective dates, name and policy number of insurance carrier, dental plan or other source and your **member identification number**.

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

Special remarks:

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 _____	**Child 4.**	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____
Spouse 2.	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____	**Child 5.**	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____
Child 3.	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____	**Child 6.**	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____

Conditions of enrollment

Applicant acknowledgments and agreements

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

1. *I acknowledge that by enrolling in the following plans, coverage is underwritten or administered by the following entities (collectively referred to as "Aetna"):
   - Aetna DMO, Aetna Dental PPO, Dental EPP, Aetna HealthFund / Aetna DentalFund, and Aetna Indemnity Dental: Aetna Life Insurance Company
   - In the states of AZ, CA, GA, MD, MO, NC, NJ and TX, Aetna DMO, Advantage and Basic plans may also be provided by one of the following: Aetna Dental of California, Inc., Aetna Dental Inc. (NJ), Aetna Dental Inc. (TX), Aetna Health Inc., or Aetna Health Inc. (AZ).
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 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 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 I am entitled to 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 (including all participating primary care dentists) 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.

E. Employee signature

☐ *By checking this box you agree to use our member self-service website for all future printed materials.*

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 this Employee Enrollment / Change Request form. I understand that in the event I fail to sign this form within 31 days after the above transaction request or that 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.

Misrepresentation: 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 may have violated state law.

Attention Colorado residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Attention Kentucky 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 may subject such person to criminal and civil penalties.

Attention Tennessee residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Employee signature *- required* **X**	***Date (Month/Day/Year)***	***Employee email address (optional)***	***Primary language spoken***

Please make a copy for your records. **Visit us at www.aetna.com.**

Instructions

Employer – Complete the **Employer group information** at the top of page 1.

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.

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 names(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, and Social Security number for each individual.
- *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.**
- **Late entrant:** If you are **not** enrolling within your employer's eligible enrollment period, check **Yes**.
- If you or your dependent(s) were covered under your employer's or other **Prior insurance plan**, check the **Yes** box(es) and provide beginning and ending effective dates, name and policy number of insurance carrier, dental plan or other source and your **member identification number** for the insurance plan in the space provided in number 1.
- If you or your dependent(s) have **Other dental coverage** and / or are **Currently covered by Medicare,** check the **Yes** box(es) and provide beginning and ending effective dates, name and policy number of insurance carrier, dental plan or other source and your **member identification number** for the insurance plan in the space provided in number 2.
- If a dependent is handicapped and financially dependent, check **Yes** and provide proof of handicapped status from the attending physician.
- If a dependent is a student, check **Yes**. Refer to your Summary Coverage for plan definitions. Aetna may request that you provide proof from the educational institution.
- Primary dentist office ID number: Locate the office ID number for the primary dentist from the appropriate provider directory or from the 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 signature:

- 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.
- By checking the box provided, you agree to use our member self-service website for all future printed materials.