Illinois Small Group Supplemental Employee Enrollment/Change Request (50 or Fewer Eligible Employees)

Instructions: You, the employee, must complete this enrollment form along with the Illinois Standard Health Employee Application for Small Employers (GR-67834-49). You are solely responsible for its accuracy and completeness.

A. Employer Information

Employer Company Name	**Group Number/Control Number** (if a current Aetna customer)

B. Enrollment Information

Effective Date	**Employee Name**	**Social Security Number**
Work Address		
Date of Hire	**Enrollment** - Check all that apply. ☐ New Group Enrollment ☐ New Hire ☐ Late Enrollee ☐ Rehire/Reinstatement ☐ Other _____	
☐ Full-time ☐ Part-time ☐ Temporary ☐ Seasonal ☐ 1099 ☐ Retired		

C. Coverage Selection – *Please print clearly, using black ink.*

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

1. Medical: ☐ Yes ☐ No

Check applicable boxes.

☐ Employee ☐ Spouse/Domestic Partner ☐ Child(ren)

Check one:

☐ **Managed Choice® (Open Access) Plan –**
Plan Option: _____

☐ **Savings Plus Plan –**
Plan Option: _____

☐ **Open Choice® PPO Plan –**
Plan Option: _____

☐ **Indemnity Plan –**
Plan Option: _____

☐ **Other Plan – Plan Option:** _____

2. Dental: ☐ Yes ☐ No

Check applicable boxes.

☐ Employee ☐ Spouse/Domestic Partner ☐ Child(ren)

To enroll, enter plan number and name elected below.

Standard Plan:
Plan Number: _____
Plan Name: _____
If *Option 3:* DMO® ☐ *or* PPO ☐

Voluntary Plan:
Plan Number: _____
Plan Name: _____
If *Option 2:* DMO® ☐ *or* PPO ☐

Out-of-State PPO Plan:
Plan Name: _____

3. Life and Disability: ☐ Yes ☐ No

Check applicable boxes.

☐ Employee ☐ Spouse/Domestic Partner ☐ Child(ren)

Check one:

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

Beneficiary Designation - **Full Name** (First, Middle, Last)

Beneficiary Social Security Number

Relationship to Employee

Did you have prior dental coverage? ☐ Yes ☐ No If "Yes," provide the following:

Name of Covered Individual	Carrier Name	Group Number	Start Date	Term Date

D. Changes – Check all that apply.

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 for age 26 and beyond. Some exceptions apply. Please refer to your plan documents or contact your benefits administrator.

	Name	Date of Birth	Social Security No.	Date of Event	Reason
☐ Add Spouse*					
☐ Add Child*					
☐ Name Change					
☐ Change Plan					
☐ Other					

Employee must be enrolled for spouse/dependent(s) to enroll for coverage.

E. Remove or Terminate – Check all that apply.

	Date of Event	Reason
☐ Employee Termination		
☐ Remove Spouse		
☐ Remove Child: Name _____		
☐ Cancel Coverage		

F. COBRA or State Continuation – Check all that apply.

☐ Employee ☐ COBRA ☐ State Continuation Qualifying Event: _____ Start Date: _____ Stop Date: _____	☐ Dependent Name: _____ ☐ COBRA ☐ State Continuation Qualifying Event: _____ Start Date: _____ Stop Date: _____	☐ Dependent Name: _____ ☐ COBRA ☐ State Continuation Qualifying Event: _____ Start Date: _____ Stop Date: _____

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: Aetna Health Inc.
   - Aetna POS: Aetna Health 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.
2. 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. For Dependent Life, dependents are eligible from 14 days of age up to their 19th birthday, or up to their 23rd birthday, if a full-time student.
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. 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.
4. 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.
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 Life Insurance Company. 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 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.
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. 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. 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 Supplemental 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	***Employee E-mail Address (optional)***	***Date (Month/Day/Year)***
X		