Aetna Enrollment/Change Request

Aetna Life Insurance Company **

Check One:
- ☐ Indemnity Dental
- ☐ Dental PPO
- ☐ Dental EPP
- ☐ DMO®
- ☐ FOC/Indemnity
- ☐ FOC/PPO
- ☐ FOC/DMO

See Instructions on the back of the front page.

A. Transaction Information — EFFECTIVE DATE (MM/DD/YR)

1. Enrollment (Check One)

- ☐ New Enrollee — Hire Date ___/___/___ (MM DD YR)
- ☐ Rehired/Reinstatement — Date ___/___/___ (MM DD YR)
- ☐ Return to Work — Date ___/___/___ (MM DD YR)

2. Change

From / To

- ☐ Social Security Number ___-___-___ ___-___-___
- ☐ Control/Suffix/Account ___ ___
- ☐ Stop Continuation of Dental Coverage (i.e., COBRA)
- ☐ Other ___

3. Termination

- ☐ Terminating Employment - Reason ___
- ☐ Cancelling Coverage - Reason ___
- ☐ Continue Employee Dental Coverage (i.e., COBRA)
- ☐ Continue Dependent Dental Coverage (i.e., COBRA)

B. Employer Information

1. Employer Name - Full Name of Business or Organization	2. Control No.	Suffix	Account	3. Plan Number	4. SFO

5. Employer Address (Street, City, State, ZIP Code) - Primary Location of Business or Organization	6. Claim Office Code	7. Customer Code (Optional)	8. Network ID

C. Employee Information - Please Print All Information

1. Employee Social Security Number	2. Employee Name (Last, First, Middle Initial)	3. Employee Home Address
___-___-___		Number, Street, Apt

4. Employee Status	5. Sex	6. Home Telephone Number	7. Work Telephone Number	
☐ Active ☐ Retired		( ) -	( ) -	City State ZIP Code

D. Individuals Covered (List individuals for whom you are electing/changing coverage.)

☐ **Check this box if you are refusing coverage for your dependents.** * Additional information required. See Instruction page.

(A)dd/New (C)hange (R)emove	Relation. Code	Name (First, Middle Initial, Last) (Explain difference in last names in Special Remarks)	Social Security Number (If dependent has no SSN, write "None")	Birthdate MM / DD / YYYY	Dependent Address (If different than employee)	Late Entrant Yes	Prior Insur. Plan Yes*	Other Dental Coverage Yes*	Currently Covered by Medicare Yes	Handi-capped Yes*	Student Age 19 or Older Yes*	Primary Care Dentist ID # / Primary Care Dentist Name	Prev. Seen Yes
	Self		___-___-___	/ /	Not Applicable	☐	☐	☐	☐	N/A	N/A	ID # / Name	☐
			___-___-___	/ /		☐	☐	☐	☐	☐	☐	ID # / Name	☐
			___-___-___	/ /		☐	☐	☐	☐	☐	☐	ID # / Name	☐
			___-___-___	/ /		☐	☐	☐	☐	☐	☐	ID # / Name	☐
			___-___-___	/ /		☐	☐	☐	☐	☐	☐	ID # / Name	☐
			___-___-___	/ /		☐	☐	☐	☐	☐	☐	ID # / Name	☐

Special Remarks

E. Acknowledgments - Signatures Required

Employee's E-mail Address:

I have read and agree to the terms of the authorization on the back of this 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.

Employee Signature X ___ Date ___ **Employer Signature** X ___ Date ___