Aetna Enrollment/Change Request

Aetna Life Insurance Company (underwriter/administrator of Dental PPO, Dental EPP and Indemnity Dental coverages)
Aetna Dental Inc. (underwriter of DMO* coverage)

Check One:

☐ **PPO Dental**

☐ **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	Prior Insur. Plan	Other Dental Coverage	Currently Covered by Medicare	Handi-capped	Student Age 19 or Older	Primary Care Dentist ID # / Primary Care Dentist Name	Prev. Seen
	Self		___-___-___	/ /	Not Applicable	Yes ☐	Yes* ☐	Yes* ☐	Yes ☐	Yes* N/A	Yes* N/A	ID # / Name	Yes ☐
			___-___-___	/ /		☐	☐	☐	☐	☐	☐	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 ___