Aetna US Healthcare

# Enrollment/Change Request

## Aetna Life Insurance Company **

*Check One:* ☐ Indemnity Dental ☐ PPO Dental ☐ 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 |
|---|---|---|---|---|---|
| | | | | | 163 |

| 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 | City | State | ZIP Code |
|---|---|---|---|---|---|---|
| ☐ Active ☐ Retired | | ( ) - | ( ) - | | | |

## 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

| (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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | Yes | Yes* | Yes* | Yes | Yes* | 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 transact 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 ______