



Aetna AFA Medical and Stop Loss Employee Enrollment/Change Form

Instructions: You must complete this enrollment form in full. If you do not, we will return it to you, and that can delay its processing. You alone are responsible for its accuracy and completeness. **If waiving coverage, please complete sections A and B.**

Employer name		Effective date	Date of hire	Member ID number (if available)
<input type="checkbox"/> New hire <input type="checkbox"/> Rehire / reinstatement <input type="checkbox"/> New group enrollment <input type="checkbox"/> Late enrollment <input type="checkbox"/> Waiver <input type="checkbox"/> Open enrollment <input type="checkbox"/> Other _____	<input type="checkbox"/> Change of coverage <input type="checkbox"/> Add spouse / civil union / domestic partner <input type="checkbox"/> Add dependent child <input type="checkbox"/> Name change <input type="checkbox"/> Other _____	<input type="checkbox"/> Employee termination <input type="checkbox"/> Remove spouse / civil union / domestic partner <input type="checkbox"/> Remove dependent child <input type="checkbox"/> Cancel coverage		<input type="checkbox"/> COBRA for: <input type="checkbox"/> Employee <input type="checkbox"/> Dependent Length of continuation: <input type="checkbox"/> 18 <input type="checkbox"/> 36 <input type="checkbox"/> Other _____ Original qualifying event date _____ Qualifying event _____ Reason _____

A. Employee information

Social Security number	Last name, first name, middle initial		Contact telephone (if we may contact you by telephone) () -	Work ZIP code	Work email address (if we may correspond with you via email)
Home address	Apt. Number	City, state			Home ZIP code
Mailing address (if different from home address)	Apt. Number	City, state			Mailing ZIP code
Number of hours worked a week _____		Check one: <input type="checkbox"/> Full time <input type="checkbox"/> 1099 <input type="checkbox"/> Seasonal <input type="checkbox"/> COBRA <input type="checkbox"/> Part time <input type="checkbox"/> Retired <input type="checkbox"/> Temporary <input type="checkbox"/> Union			

Employee acknowledgement: I understand that it is fraud to file an application for coverage, an enrollment form or claim that contains materially false information knowingly and with intent to defraud. It is illegal to conceal, for the purpose of misleading, information concerning any material fact. A person who commits fraud or intentionally misrepresents material facts is subject to civil penalties and may be charged with a crime. If you commit fraud or intentionally misrepresent material facts, your coverage can be cancelled or your rates can be increased back to your effective date.

I certify that all information and statements on this enrollment form are true and complete to the best of my knowledge. I have authority to make statements on behalf of any dependents listed on this form. If I become aware of any new information after I have completed this enrollment form but before the effective date that would change any answer on this form or make me report something not reported on this form, I agree to provide that information to Aetna as soon as possible.

Conditions of enrollment: I understand and agree that my employer's application will determine coverage and that there is no coverage unless and until Aetna approves both this enrollment form and the employer application. I agree that my employer or its agent may send this enrollment form to Aetna. I authorize all my doctors, pharmacies, hospitals and other health care providers ("providers") to give Aetna any and all personal health information about me and others listed on this form. This authorization covers all health matters 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. This authorization will remain valid for the term of the coverage and 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.

Please sign here ONLY if you are enrolling in coverage for yourself and / or dependents.

X Employee signature _____ Date (Month/Day/Year) _____

B. Decline / waive – To be completed if medical coverage is declined or refused by an eligible employee and / or their eligible family members.

I acknowledge I have been given the right to apply for this coverage; however, I am electing not to enroll. By declining this group coverage I acknowledge that I and / or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage. I and / or my dependents have made this decision of my / their own accord with no pressure from my employer, my employer's agent or the insurance carrier.

Medical coverage declined for:
☐ Myself ☐ Spouse / civil union / domestic partner ☐ Children
Please sign here **ONLY** if you are declining coverage for yourself and / or dependents.
X Employee signature _____ **Date (Month/Day/Year)** _____
C. Medical coverage selection

Plan Option _____

D. Other medical coverage – List any individuals who will have other health insurance at the same time as this coverage.

Name of individual	Carrier Name	Name of individual	Carrier Name

E. Medicare coverage – List individuals covered by Medicare.

Name of individual	Medicare Part A	Medicare Part B	Medicare Part D	Over Age 65	Disability	End-Stage Renal Disease Effective Date
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

F. Individuals enrolling – List individuals enrolling or adding, changing or removing coverage. If more space is needed check here ☐ and use a separate sheet of paper.

(A)dd (C)hange (R)emove	Last name, first name, middle initial	Sex (M/F)	Social Security number	Birthdate (MM/DD/YYYY)	Height	Weight	Tobacco or nicotine use (including E-cigarette devices)	Dependent information (List city, state and ZIP code for any dependent living at another address)
	<input type="checkbox"/> Employee 1.						<input type="checkbox"/> Yes <input type="checkbox"/> No	NA
	<input type="checkbox"/> Spouse <input type="checkbox"/> Civil union <input type="checkbox"/> Domestic partner 2.						<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other 3.						<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other 4.						<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other 5.						<input type="checkbox"/> Yes <input type="checkbox"/> No	

G. Health Questionnaire – Complete for all individuals enrolling for coverage.

Have you or anyone applying for coverage consulted with or been examined, diagnosed, or treated by any health care professionals during the last five (5) years for any illness, injury or health condition in any of the categories listed below? If "yes," please check the box that most appropriately describes the condition(s) and explain fully below (page 4).

1. Cancer / tumor / cyst ☐ Yes ☐ No
☐ Brain ☐ Breast ☐ Esophagus ☐ Stomach ☐ Colon ☐ Leukemia ☐ Lymphoma ☐ Multiple myeloma ☐ Kidney ☐ Liver ☐ Lung ☐ Melanoma ☐ Pancreas ☐ Prostate
☐ Testicular ☐ Cervical ☐ Ovarian ☐ Uterine ☐ Throat ☐ Thyroid ☐ Other cancer (type / location _____) ☐ Non-malignant tumor (type / location _____)

Diagnosis date _____ **Cancer stage (0-4)** _____ (if known) **Cancer category (In situ, localized, regional, distant)** _____ (if known)

Treatment: ☐ Surgery date _____ ☐ Chemo timeframe _____ ☐ Radiation timeframe _____

☐ Remission ☐ Yes ☐ No If yes, provide date of remission _____

Continued on next page

SG AFA IMQ Long

G. Health Questionnaire (continued)

2. Heart / vascular <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Aneurysm (location _____) <input type="checkbox"/> Blocked arteries (e.g., carotid, heart, abdomen, legs) <input type="checkbox"/> Heart attack <input type="checkbox"/> Heart valve disorder <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Irregular or abnormal heart rhythm <input type="checkbox"/> Stroke <input type="checkbox"/> Vasculitis (type _____) <input type="checkbox"/> Bypass / angioplasty / stent (location _____) <input type="checkbox"/> Pacemaker or cardiac defibrillator <input type="checkbox"/> Other (specify details below)
3. Blood / clotting disorder <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Hemophilia (specify type below) <input type="checkbox"/> Anemia (specify type below; e.g., sickle cell, hemolytic, aplastic) <input type="checkbox"/> Blood clots <input type="checkbox"/> Other (specify details below)
4. Reproductive / Gynecological <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Current pregnancy: specify if it's a spouse, dependent child or other expectant parent even if not listed on the application (due date _____, if multiples # ____, any complications _____) <input type="checkbox"/> Intending to adopt <input type="checkbox"/> Infertility <input type="checkbox"/> Other Gynecological conditions (specify details below)
5. Gastrointestinal / endocrine <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Diabetes <input type="checkbox"/> Crohn's / ulcerative colitis <input type="checkbox"/> Autoimmune hepatitis <input type="checkbox"/> Hepatitis B (specify below if acute or chronic) <input type="checkbox"/> Hepatitis C (if cured, when did treatment end? _____) <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Growth disorder <input type="checkbox"/> Adrenal, pituitary, thyroid gland disorder (specify type below) <input type="checkbox"/> Other disorders of the gallbladder, stomach, pancreas, liver, colon (specify type below)
6. Brain / neurological <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Amyotrophic lateral sclerosis <input type="checkbox"/> Cerebral palsy <input type="checkbox"/> Neuropathy / polyneuropathy <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Myasthenia gravis <input type="checkbox"/> Muscular dystrophy <input type="checkbox"/> Brain and / or spinal cord disorder or injury <input type="checkbox"/> Paralysis, quadriplegia, paraplegia <input type="checkbox"/> Other (specify details below)
7. Immune / dermatology <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> HIV or AIDS <input type="checkbox"/> Immunodeficiency disorder <input type="checkbox"/> Connective tissue disorder (specify type below; e.g., lupus, scleroderma) <input type="checkbox"/> Hereditary angioedema <input type="checkbox"/> Skin disorder (specify type below; e.g., psoriasis, eczema, ulcers, infections) <input type="checkbox"/> Other (specify details below)
8. Lung / respiratory <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cystic fibrosis <input type="checkbox"/> COPD, chronic bronchitis, emphysema <input type="checkbox"/> Pulmonary hypertension <input type="checkbox"/> Pulmonary fibrosis <input type="checkbox"/> Other (specify type below; e.g., asthma, sarcoidosis, etc.)
9. Urinary / kidney <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Kidney disease / disorder (specify type below) <input type="checkbox"/> Kidney failure <input type="checkbox"/> Dialysis: date started _____ <input type="checkbox"/> Dialysis possible within the next 18 months <input type="checkbox"/> Bladder disorder <input type="checkbox"/> Prostate disorder <input type="checkbox"/> Other (specify details below)
10. Musculoskeletal <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Rheumatoid or psoriatic arthritis (specify type below) <input type="checkbox"/> Disorder of the back / neck / spine <input type="checkbox"/> Disorder of the joints (specify location; e.g., hips, knees, shoulders) <input type="checkbox"/> Chronic pain disorder <input type="checkbox"/> Osteomyelitis <input type="checkbox"/> Amputation <input type="checkbox"/> Other (specify details below)
11. Mental health / substance abuse <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Alcohol and / or drug abuse (specify type below) <input type="checkbox"/> Eating disorder <input type="checkbox"/> Anxiety / depression <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Suicide attempt <input type="checkbox"/> Oppositional defiant / conduct disorder <input type="checkbox"/> Autism <input type="checkbox"/> ABA therapy <input type="checkbox"/> Other (specify details below)
12. Transplant <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Organ or bone marrow / stem cell transplant already performed (date _____) <input type="checkbox"/> Future transplant planned / scheduled (date _____) <input type="checkbox"/> Transplant discussed / recommended / possible within the next 18 months <input type="checkbox"/> Transplant complications <input type="checkbox"/> Other (specify details below)

Continued on next page

G. Health Questionnaire (continued)

13. Birth / inherited conditions <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Premature birth (gestational age: ____ # weeks) <input type="checkbox"/> Congenital birth defect <input type="checkbox"/> Genetic / metabolic disorder <input type="checkbox"/> Any syndrome (specify details below) <input type="checkbox"/> Other (specify details below)	
14. Eyes / ears / nose / throat <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Acoustic neuroma <input type="checkbox"/> Cataracts <input type="checkbox"/> Cleft lip / palate <input type="checkbox"/> Deviated septum <input type="checkbox"/> Glaucoma <input type="checkbox"/> Retinopathy <input type="checkbox"/> Chronic ear infections <input type="checkbox"/> Chronic sinusitis <input type="checkbox"/> Other (specify details below)	
15. Medications <input type="checkbox"/> Yes <input type="checkbox"/> No	
Current medications: Person _____ # of meds ____ Person _____ # of meds ____ (list medication name(s) and diagnosis below)	
Medications taken within the past 12 months: Person _____ # of meds ____ Person _____ # of meds ____ (list medication name(s) and diagnosis below)	
16. Incapacitated <input type="checkbox"/> Yes <input type="checkbox"/> No	
Reason: <input type="checkbox"/> Disabled <input type="checkbox"/> Handicapped <input type="checkbox"/> Congenital disorder <input type="checkbox"/> Other (specify details below)	
17. Other <input type="checkbox"/> Yes <input type="checkbox"/> No (specify details below)	
<input type="checkbox"/> Hospitalizations in the past 5 years <input type="checkbox"/> Future surgeries or hospitalizations discussed / planned / recommended / scheduled or possible within the next 18 months <input type="checkbox"/> Other conditions not addressed elsewhere in the application	

Provide details below for all "yes" answers indicated above. If additional space is needed, attach a separate sheet. All attachments must be signed and dated by the applicant.

Ques. No.	Enrollee name	Conditions / diagnosis	Date diagnosed	Treatment (include surgery, hospitalized, durable medical equipment / supplies, etc.)	Medication names (include those taken orally, injected, infused, topically, nasally, inhaled, etc.)	Dates treated	Is treatment ongoing? If yes , provide details of any current OR future treatment.