Before submitting this completed form to your employer, you may wish to protect the confidentiality of your health information by taping or stapling the form so pages 2 and 3 are not visible.

Illinois (51+ Eligible Employees)
Employee Enrollment/Change Request

Employer Name	**INSTRUCTIONS:** You, the employee, must complete this enrollment form in full or it will be returned to you resulting in a delay in processing. You are solely responsible for its accuracy and completeness. **If waiving coverage, please complete Sections B and G.**

Effective Date / **Date of Hire**				
	☐ New Hire ☐ Rehire/Reinstatement ☐ New Group Enrollment ☐ Late Enrollment ☐ Other ________	☐ Change of Coverage ☐ Add Spouse/Dependent Child ☐ Name Change ☐ Other ________	☐ Employee Termination ☐ Remove Spouse/Dependent Child ☐ Cancel Coverage	COBRA/State Continuation for: ☐ Employee ☐ Dependent Length of Continuation: ☐ 18 ☐ 36 ☐ Other ____ Original Qualifying Event Date ______ Reason ______

(Shaded sections for Employer/Aetna Use Only)

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

A. Medical Coverage Selection - *Please print clearly, using black ink.*

Check one:

☐ Aetna Choice® POS II ☐ Managed Choice® ☐ Traditional Choice® ☐ Aexcel® Plus

☐ Aetna HealthFund® ☐ Open Choice® PPO ☐ Aexcel® ☐ Other ________

B. Employee Information - *Must be completed by the employee.*

Member Aetna ID Number (if available)	Last Name, First Name, M.I.	Job Title	Home Telephone	Primary Language Spoken (Optional)

Home Address	Apt. No.	City, State	ZIP Code

Work Address	City, State	ZIP Code	Work Telephone

No. of Hours Worked Per Week	Check One	No. of Dependents Including Spouse
	☐ Part-time ☐ Full-time ☐ 1099 ☐ Retired ☐ Seasonal ☐ Temporary	

NOTE FOR MEDICAL COVERAGE: While the Federal Patient Protection and Affordable Care Act mandates coverage of dependent children up to age 26, your plan may allow coverage beyond age 26. Some exceptions apply. Please refer to your plan documents or contact your benefits administrator.

C. Individuals Covered - *List individuals for whom you are enrolling or adding/changing/removing coverage.* *Insert additional sheets if necessary.*

Name (Last, First, M.I.)	Sex M/F	Social Security Number	Relationship	Birthdate MM / DD / YYYY	Height (ft, in)	Weight (lbs)	Status	PCP Provider ID#
Employee 1.			Self				☐ Single ☐ Divorced ☐ Married ☐ Widowed ☐ Legally Separated	
Spouse 2.			☐ Spouse ☐ Other ____				☐ Different last name	
Child 3.			☐ Child ☐ Stepchild ☐ Other ____				☐ Different last name ☐ Lives at another address ☐ Disabled	
Child 4.			☐ Child ☐ Stepchild ☐ Other ____				☐ Different last name ☐ Lives at another address ☐ Disabled	

D. Dependent Information

List any dependent in Section C living at another address.	Name Reason	Address
If any dependent's last name differs from yours, explain.	Name Reason	

E. Other Insurance

Does anyone over age 19 enrolling on this enrollment form have current or prior medical and/or dental coverage? ☐ Yes ☐ No

Proof of coverage should accompany this enrollment form for pre-existing condition credit and if an employee is waiving coverage. Acceptable forms of proof are:

1. Certificate of Creditable Coverage from prior carrier, or
2. Copy of ID card or most recent payroll stub showing medical coverage deduction, or
3. Copy of most recent medical premium bill from prior carrier.

Failure to provide Proof of Prior Coverage may subject you or a family member over age 19 to the full pre-existing conditions limitation with no credit for prior coverage. You may request a Certificate of Creditable Coverage from your prior carrier. NOTE: 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.

Name of Covered Individual	Carrier Name	Group Number	Start Date	Termination Date	Health
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

F. Medicare Information

Name of Person	Medicare Part A	Medicare Part B	Medicare Part D	Over Age 65	Disability	End-Stage Renal Disease Eff Date
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

G. Declination/Waiver of Coverage - *To be completed if coverage is declined or refused by an eligible employee and/or their eligible family members.*

I understand I am eligible to apply for this coverage through my employer; however, I am waiving coverage as noted below. Check all that apply.

☐ Employee Medical

☐ Spouse Medical

☐ Child(ren) Medical

Reason for declining coverage *(If applicable attach front/back of your health ID card):*

☐ Covered by spouse's group coverage - Carrier Name and ID number: ____________________

☐ Enrolled in other insurance (check applicable box): ☐ Medicare ☐ TRICARE ☐ CHAMPVA ☐ Military ☐ Individual ☐ Retiree ☐ Other ____________

Carrier Name and ID number: ____________________

☐ Spouse covered by employer's group insurance

☐ Do Not Want

I certify I have been given the right to apply for this coverage, however, I am waiving coverage as noted above. By declining this group coverage I acknowledge that myself and/or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage. Pre-existing conditions, when enrolled in this medical plan, may not be covered for **twelve** months. NOTE: 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.

Please sign here ONLY if you are declining coverage for yourself or dependent(s). X Employee Signature	***Date (Month/Day/Year)***

H. Race/Ethnicity - Optional (This information is designed for the purpose of data collection and will not be used for determining eligibility, rating or claim payment.)

Employee 1.	☐ White - 01 ☐ African American or Black - 02 ☐ Hispanic or Latino - 03 ☐ Asian - 04 ☐ Other - 05 ________	Child 3.	☐ White - 01 ☐ African American or Black - 02 ☐ Hispanic or Latino - 03 ☐ Asian - 04 ☐ Other - 05 ________
Spouse 2.	☐ White - 01 ☐ African American or Black - 02 ☐ Hispanic or Latino - 03 ☐ Asian - 04 ☐ Other - 05 ________	Child 4.	☐ White - 01 ☐ African American or Black - 02 ☐ Hispanic or Latino - 03 ☐ Asian - 04 ☐ Other - 05 ________

I. Health Questionnaire

Health History for Individuals and Their Dependents. ***The following information is confidential and will not be seen by or given to your employer.***

- ALL of the questions must be answered by you and your dependents over age 19 or the enrollment form will be returned.
- Incomplete enrollment forms may delay the effective date of your coverage.

	Yes	No
1. Within the last 5 years has anyone applying for coverage consulted, received treatment, by a doctor, psychiatrist, psychologist, or other practitioner or been diagnosed with any of the following conditions, disorders or diseases? (Check all that apply.) .... *If a condition is not noted, please list it below in Section J.*	☐	☐

☐ Diabetes	☐ Paralysis/Paresis	☐ Pituitary/Adrenal/Growth Disorder
☐ Infertility	☐ Tumor/Cyst/Growth	☐ Arthritis/Bone/Joint/Muscle/Prosthetic Device
☐ Endocrine	☐ Systemic or Lupus	☐ Mental/Nervous/Emotional/Eating
☐ Pancreas	☐ Lung or Respiratory	☐ Stroke/Brain/Neurological/Central Nervous System
☐ Liver/Hepatitis	☐ Alcohol or Drug Use	☐ Transplant (recommended, pending or complete)
☐ Immune System	☐ Kidney/Bladder/Urinary	☐ Advised to have surgery or treatment is needed or pending
☐ Cancer or Blood	☐ Heart/Circulatory/Vascular	☐ Had medical claims in excess of $5,000
☐ Epilepsy/Seizure	☐ Digestive/Stomach/Intestinal	☐ Currently pregnant – due date: ____/____/______ (month/day/year)

	Yes	No
2. Has anyone applying for coverage been prescribed medications in the past 12 months?	☐	☐
3. Does anyone applying for coverage have a known condition that requires on-going treatment?	☐	☐
4. Do you or spouse use tobacco products, including cigarettes, pipe, cigars, or chewing tobacco? .... If Yes, check applicable boxes: ☐ Employee ☐ Spouse	☐	☐

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS ABOVE, YOU MUST COMPLETE SECTION J ON THE FOLLOWING PAGE.

J. Health Questionnaire - Details for "Yes" Responses in Section I.

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS IN SECTION I, YOU MUST COMPLETE THE FOLLOWING.
Please provide us with FULL DETAILS for each "Yes" answer to any condition(s) checked in Section I. **In addition**, please give details below of last doctor visit and/or physical examination for **ALL** family members listed regardless of the date or reason. *(Insert additional sheets if necessary.)*

Question Number	Name of Individual	Condition/Diagnosis	Date of Onset	Date Treatment Ended	Medication Prescribed	Dosage	Still Taking Medication
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

If you are providing additional sheets, check here ☐ and insert the sheets before sealing this Enrollment form.

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 Managed Choice (Open Access): Aetna Life Insurance Company
   - Aetna Choice POS II: Aetna Health Inc. and Aetna Health Insurance Company
   - All other health coverages: Aetna Life Insurance Company
2. I understand and agree that my employer's enrollment form willl 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.
3. I understand and agree that this Enrollment/Change Request may be transmitted to Aetna or its agent. I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("Providers"), including pharmacies or pharmacy database benefit managers to give Aetna or its agent information concerning the medical history, prescription utilization history, services or treatment provided to anyone listed on this Enrollment/Change Request, 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. 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.

   Notice: Neither the brokers that handled this insurance nor the insurers, that have underwritten this insurance, will disclose Non-Public Personal Information concerning the buyer to non-affiliates of the brokers or insurers, except as permitted by law.

continued on next page

Conditions of Enrollment *(continued)*

4. The plan documents will determine the rights and responsibilities of member(s) and will govern in the event they conflict 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 Inc. 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. Pre-existing conditions, when enrolled in this medical plan, may not be covered for **twelve** months. NOTE: 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

7. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, denial of insurance and civil damages. Any person who knowingly and with intent to defraud any insurance company or other person files any 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 supplied in this form is true and complete. I have read and agree to the Conditions of Enrollment and Misrepresentation on this Illinois (51+ Eligible Employees) Employee Enrollment/Change Request. 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		