

Banner Health and Aetna Health Insurance Company
Banner Health and Aetna Health Plan Inc.

Aetna Life Insurance Company
Aetna Health Inc.

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 you are declining coverage, you must complete section C.** Please use only black ink to complete this form.

Member ID number (if available)

Employer group information – To be completed by employer

Employer/company name – full name of business or organization
Employer address (street, city, state, ZIP code) – primary location of business or organization

A. Type of activity – Employee completes sections A – F. Please print clearly.

Effective date	<input type="checkbox"/> New hire	<input type="checkbox"/> Add spouse	<input type="checkbox"/> Employee termination date
	<input type="checkbox"/> Rehire/reinstatement	<input type="checkbox"/> Add domestic partner	<input type="checkbox"/> Remove spouse
Date of hire	<input type="checkbox"/> New group enrollment	<input type="checkbox"/> Add dependent child	<input type="checkbox"/> Remove domestic partner
	<input type="checkbox"/> Late enrollment	<input type="checkbox"/> Change of coverage	<input type="checkbox"/> Remove dependent child
	<input type="checkbox"/> Waiver	<input type="checkbox"/> Name change	<input type="checkbox"/> Cancel coverage
	<input type="checkbox"/> Open enrollment		<input type="checkbox"/> Other _____
	<input type="checkbox"/> Loss of coverage		
<input type="checkbox"/> COBRA <input type="checkbox"/> State continuation for: <input type="checkbox"/> Employee <input type="checkbox"/> Dependent Length of continuation: <input type="checkbox"/> 18 months <input type="checkbox"/> 36 months <input type="checkbox"/> Other _____ Qualifying event _____ Original qualifying event date _____ Loss of coverage date _____			

B. Employee information – You must complete this section.

Social Security number	Last name, first name, middle initial		Job title
Home address	Apt. number	City, state	ZIP code
Work address	City, state		ZIP code
Home/cell telephone () -	Work telephone () -	Number of hours worked a week	Employee email
Primary language spoken (optional)	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"/> Retiree <input type="checkbox"/> Temporary <input type="checkbox"/> Union		

C. Declining coverage – Check all that apply.

I understand I am eligible to apply for this coverage through my employer. However, I am declining the coverage I checked below:			
<input type="checkbox"/> Employee:	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Reason for declining coverage <input type="checkbox"/> Parental group coverage <input type="checkbox"/> Spouse/domestic partner group coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Retiree coverage <input type="checkbox"/> COBRA coverage	<input type="checkbox"/> Insurance through another job
<input type="checkbox"/> Spouse/domestic partner:	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		<input type="checkbox"/> TRICARE/Military coverage
<input type="checkbox"/> Children:	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		<input type="checkbox"/> Individual coverage – On Exchange <input type="checkbox"/> Individual coverage – Off Exchange <input type="checkbox"/> Another group plan provided by my employer
			<input type="checkbox"/> Do not want <input type="checkbox"/> Other _____

I certify I have the right to apply for this coverage. However, I am declining coverage as noted above. 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.

Please sign here ONLY if you are declining coverage for yourself and/or dependents. <input type="checkbox"/> I am declining coverage. Employee signature: X	Date (Month/Day/Year)
Please PRINT employee name:	

D. Plan options – Check one plan. Your selection must be offered by your employer.

Control number	Suffix	Account	Plan number	Customer Code
1. Medical <input type="checkbox"/> Yes <input type="checkbox"/> No <i>To enroll, check "yes" and enter the plan option elected below. Please print clearly.</i> Plan option _____ You may only select a plan offered by your employer. <i>Banner Health and Aetna Health Insurance Company, Banner Health and Aetna Health Plan Inc., Aetna Health Inc. and/or Aetna Life Insurance Company, underwrite/administer medical coverage.</i>				

Control number	Suffix	Account	Plan number	
2. Dental <input type="checkbox"/> Yes <input type="checkbox"/> No <i>To enroll, check "yes" and enter the plan option elected below. Please print clearly.</i> Plan option/name _____ If FOC, choose: <input type="checkbox"/> DMO® or <input type="checkbox"/> PPO/Indemnity You may only select a dental plan if your employer offers dental coverage. Before today, were you covered under this employer's dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Employees in AZ, CA, GA, MA, MD, MO, NC, NJ and TX must either live or work within the approved DMO® service area to be eligible to enroll in the DMO®. For groups 51-100 only: Creditable coverage is allowed for new members enrolling in voluntary takeover groups. New hires please see below if applicable: New Hire selecting a Voluntary plan and your Aetna plan is a takeover group: Were you covered for 12 months under a dental plan within the last 90 days that included both Preventive and Basic coverage? Discount dental and preventive only plans do not apply. <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Aetna Health Inc. underwrites the Aetna DMO® dental plans. Aetna Life Insurance Company underwrites all other Aetna dental plans.</i>				

Control number	Suffix	Account	Plan number	
3. Aetna VisionSM Preferred <input type="checkbox"/> Yes <input type="checkbox"/> No <i>To enroll, check "yes" and enter the plan option elected below. Please print clearly.</i> Plan option/name _____ You may only select a vision plan if your employer offers vision coverage. <i>Aetna Life Insurance Company underwrites Vision insurance plans. First American Administrators, Inc. provides certain claims administration services. EyeMed Vision Care, LLC ("EyeMed") provides certain network administration services.</i>				

E. Individuals covered – List individuals for whom you are enrolling or adding, changing or removing coverage. Please complete all information for all individuals. Add more sheets if needed. NOTE FOR MEDICAL COVERAGE: While the Affordable Care Act mandates coverage of dependent children up to age 26, your plan may allow coverage beyond age 26. Please refer to your plan documents or contact your benefits administrator. Enter domestic partner only if your employer has elected that coverage.

1	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Employee name (Last, first, middle initial) _____	Sex (M/F)
Birthdate (MM/DD/YYYY) _____ / ____ / ____		Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally separated	Choosing coverage for: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Primary care physician (PCP) provider ID number _____		Current patient <input type="checkbox"/> Yes	Dental provider office ID number _____ Current patient <input type="checkbox"/> Yes
2	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Name (Last, first, middle initial) _____ <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner	Sex (M/F) _____ Social Security number _____
Birthdate (MM/DD/YYYY) _____ / ____ / ____		Choosing coverage for: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	
PCP provider ID number _____		Current patient <input type="checkbox"/> Yes	Dental provider office ID number _____ Current patient <input type="checkbox"/> Yes
3	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Name (Last, first, middle initial) _____ <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____	Sex (M/F) _____ Social Security number _____
Birthdate (MM/DD/YYYY) _____ / ____ / ____		Incapacitated <input type="checkbox"/> Yes <input type="checkbox"/> No	Choosing coverage for: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
PCP provider ID number _____		Current patient <input type="checkbox"/> Yes	Dental provider office ID number _____ Current patient <input type="checkbox"/> Yes

Continued on next page

E. Individuals covered (Continued)

4	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Name (Last, first, middle initial)	<input type="checkbox"/> Child <input type="checkbox"/> Other _____	<input type="checkbox"/> Stepchild	Sex (M/F)	Social Security number
Birthdate (MM/DD/YYYY) / /		Incapacitated <input type="checkbox"/> Yes <input type="checkbox"/> No		Choosing coverage for: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		
PCP provider ID number		Current patient <input type="checkbox"/> Yes		Dental provider office ID number		Current patient <input type="checkbox"/> Yes

5	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Name (Last, first, middle initial)	<input type="checkbox"/> Child <input type="checkbox"/> Other _____	<input type="checkbox"/> Stepchild	Sex (M/F)	Social Security number
Birthdate (MM/DD/YYYY) / /		Incapacitated <input type="checkbox"/> Yes <input type="checkbox"/> No		Choosing coverage for: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		
PCP provider ID number		Current patient <input type="checkbox"/> Yes		Dental provider office ID number		Current patient <input type="checkbox"/> Yes

6	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Name (Last, first, middle initial)	<input type="checkbox"/> Child <input type="checkbox"/> Other _____	<input type="checkbox"/> Stepchild	Sex (M/F)	Social Security number
Birthdate (MM/DD/YYYY) / /		Incapacitated <input type="checkbox"/> Yes <input type="checkbox"/> No		Choosing coverage for: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		
PCP provider ID number		Current patient <input type="checkbox"/> Yes		Dental provider office ID number		Current patient <input type="checkbox"/> Yes

F. Dependent information

List any dependent in section E with a different last name or living at another address.

Name	Address

G. Coordination of benefits

Will you have other health insurance at the same time as this coverage? Yes No

If **yes**, will the Banner|Aetna and/or Aetna coverage you're applying for replace the coverage you have now? Yes No

Name of person	Carrier name	Name of person	Carrier name

Conditions of enrollment

I acknowledge that by enrolling in a Banner|Aetna and/or Aetna plan, coverage is underwritten or administered by Banner Health and Aetna Health Insurance Company, Banner Health and Aetna Health Plan Inc., Aetna Life Insurance Company and/or Aetna Health Inc. For Vision coverage, First American Administrators, Inc. provides certain claims administration services. EyeMed Vision Care, LLC ("EyeMed") provides certain network administration services.

1. My employer's application determines coverage. I don't have coverage until Banner|Aetna and/or Aetna approves my employee enrollment form and the employer application. Even if Banner|Aetna and/or Aetna approves the employer application, material misstatements or omissions may result in denial of future claims. Banner|Aetna and/or Aetna may rescind or reevaluate my coverage under the policy, as of the effective date, for eligibility and rating purposes. If Banner|Aetna and/or Aetna voids or rescinds coverage, I may be entitled to a refund of any paid premiums from the effective date of coverage. Banner|Aetna and/or Aetna will give at least 30 days advance written notice to any covered person affected by the proposed rescission. If I elect to receive electronic notifications, I will receive this notice in an electronic (email) format.

Continued on next page

Conditions of enrollment (Continued)

2. To support the coverages listed on this enrollment form, Banner|Aetna and/or Aetna may need information about medical history, services or treatment provided to anyone listed on this form. This may include minimally necessary information about mental health and substance use disorder. In accordance with HIPAA regulations, I authorize that the following entities can provide this information to Banner|Aetna and/or Aetna or its agents:
- Physicians
 - Other healthcare professionals
 - Hospitals
 - Other healthcare organizations (“providers”), including
 - Pharmacies
 - Pharmacy database benefit managers
3. In accordance with HIPAA regulations, I authorize Banner|Aetna and/or Aetna to use and disclose such minimally necessary information to:
- Affiliates
 - Providers
 - Other insurers
 - Third party administration
 - Vendors
 - Consultants
 - Governmental authorities with jurisdiction when necessary for:
 - Care or treatment
 - Payment for services
 - Operation of my health plan
 - Conduct related activities
4. I discussed the terms of this authorization with my competent adult dependents. This authorization is valid for 30 months from the signature date. This authorization is valid for the term of the coverage for medical information collected in connection with a medical claim. This authorization is voluntary. But if I don't sign this form, my ability to enroll in the plan may be affected. I have the right to revoke this authorization in writing to Banner|Aetna and/or Aetna at any time. I can't revoke authorization for information already used or disclosed before I revoked my authorization. I am entitled to receive a copy of this authorization upon request. A photocopy is as valid as the original.
- The Group Agreement/Group Policy determines the rights and responsibilities of members and will govern in the event they conflict with any:
 - Benefits comparison
 - Summary
 - Other description of the plan
 - Participating physicians, hospitals and other health care providers are independent contractors. They are not Banner|Aetna and/or Aetna agents or employees. We cannot guarantee the availability of any particular provider. Any provider network is subject to change. We will provide a notice of the change in accordance with applicable state law.
5. I understand that, with certain exceptions described in the plan documents, HMO and DMO® plans only provide coverage for covered benefits. The plan documents also describe if I need a referral for certain procedures, and who can provide care. Covered services must be performed by:
- Participating primary care physicians
 - Participating primary care dentists
 - Participating specialists
 - Participating hospitals
 - Participating pharmacies
 - Participating dentists
 - Other participating providers as authorized by a referral from a participating primary care physician
6. I authorize the substitution of generic pharmaceuticals for the brand-name products, as provided by law, for prescriptions filled under any pharmacy benefit.

I represent that all information supplied in this form is true and complete to the best of my knowledge and belief. I agree to the conditions of enrollment on this Employee Enrollment Form. I understand that, if I don't sign this form within 31 days, or Banner|Aetna and/or Aetna does not receive the request within a reasonable time, my eligibility may be affected.

I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments required for coverage.

To receive documents online, please visit your secure member account at banneretna.com.

Please sign here ONLY if you are enrolling in coverage for yourself and/or dependents.
Employee signature (required)

X

Date (Month/Day/Year)