



Small Group Employee Enrollment/Change Form



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

**Aetna Life Insurance Company
Aetna Health Inc.
Aetna Health Insurance Company**

| |
|---------------------------------|
| Group number |
| Member ID number (if available) |

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 B.** Please use only black ink to complete this form.

| | | | |
|---|---|---|---|
| Company name | | | |
| Effective date | <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"/> Loss of coverage | <input type="checkbox"/> Add spouse <input type="checkbox"/> Add domestic partner <input type="checkbox"/> Add dependent child <input type="checkbox"/> Change of coverage <input type="checkbox"/> Name change | <input type="checkbox"/> Employee termination date _____ <input type="checkbox"/> Remove spouse <input type="checkbox"/> Remove domestic partner <input type="checkbox"/> Remove dependent child <input type="checkbox"/> Cancel coverage <input type="checkbox"/> Other _____ |
| Date of hire | | | |
| <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 _____ | | | |

A. Employee information - You must complete this section. Please print clearly.

| | | | | |
|--|--|-------------------------------|---|------------------------------------|
| Social Security number | Last name, first name, middle initial | | Job title | |
| Home address | | Apt. number | City, state | |
| Work address | | City, state | | ZIP code |
| Home/cell telephone () - | | Work telephone () - | | Primary language spoken (optional) |
| Number of dependents, including spouse or domestic partner, enrolling for medical coverage | | | | |
| Salary \$ _____ | <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly | 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"/> Retiree <input type="checkbox"/> Temporary <input type="checkbox"/> Union | |
| Employee email | | | | |

B. 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 | Reason for declining coverage <input type="checkbox"/> Parental group coverage <input type="checkbox"/> Spouse group coverage <input type="checkbox"/> 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"/> TRICARE / Military coverage <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 _____ |
| | <input type="checkbox"/> Vision | | |
| <input type="checkbox"/> Spouse: | <input type="checkbox"/> Medical | <input type="checkbox"/> Dental | |
| | <input type="checkbox"/> Vision | | |
| <input type="checkbox"/> Domestic partner: | <input type="checkbox"/> Medical | <input type="checkbox"/> Dental | |
| | <input type="checkbox"/> Vision | | |
| <input type="checkbox"/> Children: | <input type="checkbox"/> Medical | <input type="checkbox"/> Dental | |
| | <input type="checkbox"/> Vision | | |
| I certify I have been given 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: | | | |

C. Coverage selection

| Control/Group number | Suffix | Account | Plan number | Class code |
|---|--------|---------|-------------|------------|
| 1. Medical <input type="checkbox"/> Yes <input type="checkbox"/> No <i>To enroll, check one and enter the plan option elected following the plan type below.</i> | | | | |
| <input type="checkbox"/> AZ Banner Open HMO – Plan option _____ | | | | |
| <input type="checkbox"/> AZ HMO – Plan option _____ | | | | |
| <input type="checkbox"/> AZ HNOption – Plan option _____ | | | | |
| <input type="checkbox"/> AZ Banner Perf OAMP – Plan option _____ | | | | |
| <input type="checkbox"/> AZ Banner Perf OAMP – HSA Compatible – Plan option _____ | | | | |
| <input type="checkbox"/> AZ Banner Broad PPO – Plan option _____ | | | | |
| <input type="checkbox"/> AZ Banner Broad PPO – HSA Compatible – Plan option _____ | | | | |
| <input type="checkbox"/> AZ Banner OOS Broad PPO – Plan option _____ | | | | |
| <input type="checkbox"/> AZ OOS Broad PPO – Plan option _____ | | | | |
| <input type="checkbox"/> AZ OOS Broad PPO – HSA Compatible – Plan option _____ | | | | |
| <input type="checkbox"/> AZ Indemnity – Plan option _____ | | | | |
| <input type="checkbox"/> Other – Plan option _____ | | | | |

Banner Health and Aetna Health Plan Inc. underwrite the Banner HMO plans. Banner Health and Aetna Health Insurance Company underwrite the Banner Open Access Managed Plus plans, Banner PPO plans and Banner Indemnity plans. Aetna Health Inc. underwrites the AZ HMO plans. Aetna Health Inc. and Aetna Health Insurance Company underwrite the AZ HNOption plans. Aetna Life Insurance Company underwrites the AZ OOS Broad PPO plans, AZ Indemnity plans and the other plan options and will provide medical coverage for those members not eligible for Banner/Aetna medical plan options.

| Control/Group number | Suffix | Account | Plan number | |
|---|--------|---------|-------------|--|
| 2. Dental <input type="checkbox"/> Yes <input type="checkbox"/> No <i>To enroll, enter the plan number and name below.</i> | | | | |
| Non-voluntary plans – Plan number _____ Plan name _____ | | | | |
| If FOC, choose: <input type="checkbox"/> Managed Dental or <input type="checkbox"/> PPO | | | | |
| Voluntary plans – Plan number _____ Plan name _____ | | | | |
| If FOC, choose: <input type="checkbox"/> Managed Dental or <input type="checkbox"/> PPO | | | | |
| Before today, were you covered under this employer's dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 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 | | | | |
| 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®. | | | | |
| <i>Aetna Health Inc. underwrites Aetna dental DMO® plans. Aetna Life Insurance Company underwrites all other Aetna dental plans.</i> | | | | |

| Control/Group number | Suffix | Account | Plan number | |
|---|--------|---------|-------------|--|
| 3. Aetna VisionSM Preferred <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| <i>Aetna Life Insurance Company underwrites Aetna vision plans. First American Administrators, Inc. provides certain claims administration services. EyeMed Vision Care, LLC ("EyeMed") provides certain network administration services.</i> | | | | |

D. Individuals covered – List individuals for whom you are enrolling or adding, changing or removing coverage. 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.

| | | | | |
|---|---------------------------------|---|--|---|
| 1 | <input type="checkbox"/> Add | Employee name (Last, first, middle initial) | Sex (M/F) | |
| | <input type="checkbox"/> Change | | | |
| | <input type="checkbox"/> Remove | | | |
| | | | | |
| 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 | Name (Last, first, middle initial) <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner | Sex (M/F) Social Security number | |
| | <input type="checkbox"/> Change | | | |
| | <input type="checkbox"/> Remove | | | |
| | | | | |
| 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 | Name (Last, first, middle initial) <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____ | Sex (M/F) Social Security number | |
| | <input type="checkbox"/> Change | | | |
| | <input type="checkbox"/> Remove | | | |
| | | | | |
| 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 |
| 4 | <input type="checkbox"/> Add | Name (Last, first, middle initial) <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____ | Sex (M/F) Social Security number | |
| | <input type="checkbox"/> Change | | | |
| | <input type="checkbox"/> Remove | | | |
| | | | | |
| 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 | Name (Last, first, middle initial) <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____ | Sex (M/F) Social Security number | |
| | <input type="checkbox"/> Change | | | |
| | <input type="checkbox"/> Remove | | | |
| | | | | |
| 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 | Name (Last, first, middle initial) <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____ | Sex (M/F) Social Security number | |
| | <input type="checkbox"/> Change | | | |
| | <input type="checkbox"/> Remove | | | |
| | | | | |
| 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 |

E. Dependent information

| | |
|--|----------------|
| List any dependent in section D with a different last name or living at another address. | |
| Name | Address |
| | |
| | |
| | |
| | |

F. Coordination of benefits

| | | | |
|--|---------------------|-----------------------|---------------------|
| Will you have other health insurance at the same time as this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| If yes , will the Banner Aetna coverage you're applying for replace the coverage you have now? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Name of person | Carrier name | Name of person | Carrier name |
| | | | |
| | | | |
| | | | |

Conditions of enrollment and authorizations

I understand that the following legal entities underwrite the plans I apply for:

- *Banner Health and Aetna Health Plan Inc. underwrite the Banner HMO plans.*
- *Banner Health and Aetna Health Insurance Company underwrite the Banner Open Access Managed Plus plans, Banner PPO plans and Banner Indemnity plans.*
- *Aetna Health Inc. underwrites the AZ HMO plans*
- *Aetna Health Inc. and Aetna Health Insurance Company underwrite the AZ HNOption plans*
- *Aetna Health Inc. underwrites the Aetna dental DMO® plans.*
- *Aetna Life Insurance Company underwrites the AZ OOS Broad PPO plans, AZ Indemnity plans and the other medical plan options, Aetna vision plans and all other dental plans.*

1. My employer's application determines coverage. I don't have coverage until Banner|Aetna approves my employee enrollment form and the employer application. Even if Banner|Aetna approves the employer application, any misstatements or omissions may result in denial of future claims. Banner|Aetna may rescind or reevaluate my coverage under the policy, as of the effective date, for eligibility and rating purposes. If Banner|Aetna voids or rescinds coverage, I may be entitled to a refund of any paid premiums from the effective date of coverage. Banner|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.
2. To support the coverages listed on this enrollment form, Banner|Aetna may need information about medical history, services or treatment provided to anyone listed on this form. This may include information about mental health and substance use disorder. I authorize that the following entities can provide this information to Banner|Aetna or its agents:
 - Physicians
 - Other healthcare professionals
 - Hospitals
 - Other healthcare organizations ("providers"), including
 - Pharmacies
 - Pharmacy database benefit managers
3. I authorize Banner|Aetna to use and disclose such 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. They agreed to these terms. 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 at any time. I can't revoke authorization for information already used or disclosed before I revoked my authorization. I or my authorized representative are entitled to receive a copy of this authorization upon request. A photocopy is as valid as the original.

Continued on next page

Conditions of enrollment and authorizations (Continued)

- 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
 - I understand and agree that, with the exception of members of the CVS Health family of companies (which includes CVS Pharmacy, CVS Caremark Mail Service Pharmacy, MinuteClinic and CVS Specialty Infusion Services), all other participating providers and vendors are independent contractors and are neither agents nor employees of Banner|Aetna or its affiliates. We cannot guarantee the availability of any particular provider outside of our corporate family and the providers in our network may change. We also do not guarantee any results or outcome of a health or dental care service. Notice of any change shall be provided 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 network 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.
7. I authorize deductions from my earnings for any contributions required for coverage, and I agree to make any necessary payments as required for coverage.

I represent that all information supplied in this form is true and complete. I have read and agree to the Conditions of enrollment and authorizations on this Employee Enrollment / Change Form. I understand that if I don't sign this form within 31 days or Banner|Aetna does not receive the transaction request within a reasonable time, my eligibility may be affected. I am employed by the employer shown on page 1. I am working full time at least 30 hours a week for this employer at the regular place of business.

The undersigned applicant and the agent certify that the applicant has read, or had read to him, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in the loss of coverage under the policy.

To receive documents online, please visit your secure member account at <https://www.BannerAetna.com>.

| | |
|--|-------------------------------------|
| <p>Please sign here ONLY if you are enrolling in coverage for yourself and / or dependents. Employee signature X</p> | <p>Date (Month/Day/Year)</p> |
|--|-------------------------------------|