Life and Disability Enrollment/Change Request

Aetna Life Insurance Company

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

A. Transaction Information

1. Enrollment
- ☐ New Employee ☐ Retiree
- ☐ Rehire/Reinstatement

Effective Date (MM/DD/YYYY) _____

Date of Hire (MM/DD/YYYY) _____

Requested Employee Coverage
- ☐ Basic Life
- ☐ AD&PL/AD&D
- ~~☐ Supplemental Life~~
- ~~☐ Supplemental AD&PL/AD&D~~
- ☐ Short Term Disability
- ~~☐ Long Term Disability~~

Requested Dependent Coverage
- ☐ Basic Dependent Life
- ☐ Basic Dependent AD&PL/AD&D
- ☐ Supplemental Dependent Life
- ☐ Supplemental Dependent AD&PL/AD&D

2. Termination (Cancel)
- ☐ Employee *

* Employee must be enrolled for dependent(s) to have coverage.

Effective Date (MM/DD/YYYY) _____

3. Change (*Provide explanation in Section D, Special Remarks.)
- ☐ Add Dependent(s) (Life ONLY)
- ☐ Remove Dependent(s) (Life ONLY)
- ☐ Plan Change
- ☐ Increase/Decrease Benefit Amount*
- ☐ Other*

Effective Date (MM/DD/YYYY) _____

B. Employer Information - Please Print all Information

1. Employer Name - Full Name of Business or Organization	2. Control No.	Suffix	Account	3. Plan Number	4. SFO
	866304				

5. Employer Address (Street, City, State, ZIP Code) - Primary Location of Business or Organization	6. Claim Office Code	7. Customer Code (Optional)

C. Employee Information - Please Print all Information

1. Employee Social Security Number	2. Employee Name (Last, First, M.I)	3. Birthdate (MM/DD/YYYY)	4. Sex	5. Telephone Numbers
- -		/ /		Home ( ) - Work ( ) -

6. Employee Home Address (Number, Street, Apt. No., City, State, ZIP Code)	# hrs./week:	7. Employee Annual Earnings	8. Occupation/Title	9. Work State
		$		

10. Employee Coverage Amounts - Based on the requirements of your Plan, you may have to submit evidence of good health. (Life Insurance ONLY)

Basic Life Amount	Supplemental Life Amount	Basic AD&PL/AD&D Amount	Supplemental AD&PL/AD&D Amount
$	$	$	$

11. Beneficiary Designation - If more than one beneficiary, use Special Remarks. Dependent coverage Beneficiary is always the Employee. (Life Insurance ONLY)

Full Beneficiary Name (First, Middle, Last)	Social Security Number of Beneficiary	Relationship to Employee
	- -	

D. Covered Dependents - Complete only if Dependent Coverage is offered under your Plan.

☐ **Check this box if you are refusing coverage for your dependents. (Life Insurance ONLY)**

(A)dd/New (C)hange (R)emove	Dependent Name (First, Middle Initial, Last)	Social Security Number (If dependent has no SSN, write "None")	Relation. Code	Birthdate MM / DD / YYYY	Full Time Student Yes No	Basic Dependent Amount	Supplemental Dependent Amount	Basic Dependent AD&PL/AD&D Amount	Supplemental Dependent AD&PL/AD&D Amount
		- -		/ /	☐ ☐	$	$	$	$
		- -		/ /	☐ ☐	$	$	$	$
		- -		/ /	☐ ☐	$	$	$	$
		- -		/ /	☐ ☐	$	$	$	$

Special Remarks

E. Certification - Signatures Required

Employee's E-mail Address:

My signature below signifies my agreement with the statements and authorization under the **Certification and Authorization** section and the **Misrepresentation** section on the back of this form.

1. Employee Signature *(Required)*	Date	2. Employer Signature *(Required)*	Date
X _____		X _____	

Certification and Authorization	I certify that all information on this form is true and complete to the best of my knowledge and belief. I understand that this insurance is subject to all of the terms of the Plan of Insurance contained in the group policy and summarized in the announcement material provided me and the certificate issued to me. I understand that the effective date of insurance for myself or for any of my dependents is subject to my being actively at work on that date and that the effective date of insurance for any of my dependents is also subject to the dependent health condition requirements of the Plan. Further, I understand that any insurance subject to evidence of good health or medical information will not become effective until Aetna gives its written consent. I understand that, in the event I fail to sign this form within 31 days of the effective date of eligibility or that for any reason Aetna does not receive notice of the Enrollment/Change Request within a reasonable time following the date I was eligible to enroll or change my coverage, my and my dependents' eligibility may be affected. I request my employer to arrange for the issuance of Group Life Coverage and/or Group Disability Coverage for which I am or may become eligible and authorize deductions of the required contributions from my earnings.
Misrepresentation	Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application 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. **Attention Arkansas and West Virginia Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Attention California, Ohio and Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application 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. **Attention Colorado Residents:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. **Attention Kentucky Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application 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 may subject such person to criminal and civil penalties. **Attention Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits. **Attention New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. **Attention North Carolina Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application 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 may be a crime and subjects such person to criminal and civil penalties. **Attention Oklahoma Residents:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **Attention Oregon Residents:** Any person who with intent to injure, defraud or deceive any insurance company or other person submits an 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 may have violated state law. **Attention Puerto Rico Residents:** Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years. **Attention Vermont Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application 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 may be a crime and may subject such person to criminal and civil penalties. **Attention Virginia Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application 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 act, which is a crime and subjects such person to criminal and civil penalties.

Instructions - Instructions are provided only for those fields which are not self-explanatory or for which you may need additional information.

A. Transaction Information

*Make sure you complete the **Effective Date** in Section **A** - Transaction Information.*

*Make sure you read Section **E**. **Sign Name and date.***

To Enroll

- Complete ***Effective Date*** and ***Date of Hire*** in Section **A** - Transaction Information.
- Check the box(es) applicable to the benefit(s) you wish to enroll for in Section **A** - Transaction Information, Number **1** - *Enrollment, Requested Employee Coverage* and *Requested Dependent Coverage.*
- Complete **all** blank fields in Section **B** - Employer Information *and* Section **C** - Employee Information.
- Complete Section **D** - Covered Dependents for all dependents for whom you are electing coverage. Complete **ALL** items for each individual listed.
- Make sure you read Section **E** - Certification. Sign Name and Date.

To Terminate (Cancel)

- Complete ***Effective Date*** in Section **A** - Transaction Information, Number **2** and check appropriate box.
- Complete all blank fields in Section **B** - Employer Information *and* Section **C** - Employee Information.
- Make sure you read Section **E** - Certification. Sign Name and Date.

To Change

- Complete ***Effective Date*** in Section **A** - Transaction Information, Number **3** and check appropriate box(es).
- Complete blank fields in Section **B** - Employer Information (if applicable).
- Complete Section **C** - Employee Information.
- Indicate change(s) in appropriate Section(s) (**B, C, D**) and ***circle.***
- Make sure you read Section **E** - Certification. Sign Name and Date.

B. Employer Information

The Servicing Field Office (B4) and Claim Office Code (B6) are assigned by Aetna.

B2. **Control, Suffix and Account** - If this information is not preprinted, provide the complete Control, Suffix and Account numbers.

B3. **Plan Number** - If this information is not preprinted, refer to the Plan Sheet to determine the correct Plan Number.

B7. **Customer Code (Optional)** - Provide an identifying Customer Code for the employee only if you had elected to provide this information.

C. Employee Information

To be completed by Enrollee.

C3. **Birthdate** - Date of birth should include **four digit year of birth.**

C10. **Employee Coverage Amounts** - Consult your Benefits Administrator to identify which earnings/insurance amounts need to be reported. Complete the appropriate box and enter the rounded dollar amount.

C11. **Beneficiary Designation** - *Full Beneficiary Name (First, Middle and Last)*, Social Security Number and relationship of the person to whom benefits will be paid in the event of your death.

D. Covered Dependents

To be completed by Enrollee.

List only those individuals for whom you are electing/ changing coverage and complete ALL items for each individual listed.

- **Add/Change/Remove** - Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- **Name** - This **must** be completed for all individuals for whom you are electing or changing coverage. Please complete **ALL** items in Section **D** for each individual listed. Attach another form if you are requesting coverage for additional dependents.
- **Relationship Code** - Use **ONLY**: H=Husband, W=Wife, N=Divorced Spouse, S=Son, D=Daughter, Y=Sponsored Male, X=Sponsored Female. **If the dependent is NOT your spouse or a biological or legally adopted child, please indicate relationship to employee in Special Remarks.**
- **Birthdate** - Date of birth should include **four digit year of birth.**
- **Full Time Student** - Defined as: Unmarried dependent child (refer to your Summary of Coverage for age limitations), regularly attends school and depends solely on the enrollee for support. Proof from the educational institution may be requested.
- **Insurance Amounts** - Consult your Benefits Administrator to identify which insurance amounts need to be reported. Complete the appropriate box(es).
- **Special Remarks** - Use this space to provide additional information or explanations. The Tobacco Use question must be completed.

E. Certification

Signatures Required

- Read the information contained above the space provided for your signature in Section **E** and the information on the back of the form.
- **Sign name and date the form.**