

Coverage is provided by the following entities: Aetna Health Inc., Aetna Health Insurance Company and Aetna Life Insurance Company for POS plans and Aetna Life Insurance Company for all other coverage.



Arizona Group Business Employee Change of Coverage Application

(For Existing Enrollments Only)

Instructions:

Before requesting a different plan, please read the Aetna brochure describing the plan you are thinking of choosing.

Be sure you are acquainted with the benefits, co-payments, annual deductibles and the limitations and exclusions of the plan you choose. The plan you choose must be part of your employer's Small Group benefit coverage.

- You, the employee, must complete this application.** You are solely responsible for its accuracy and completeness.
- All questions must be answered in full and all signatures and dates must be included where noted; otherwise, the application may be returned to you, resulting in a delay in processing and possibly a delay in the effective date of coverage.
- Type or print clearly using blue or black ink.**

1. Choice of Coverage – Please change my coverage to:

Control/Group No.	Suffix	Account	Plan No.	Class Code	Control/Group No.	Suffix	Account	Plan No.	Control/Group No.	Suffix	Account	Plan No.
A. Medical - Check one. <input type="checkbox"/> HMO \$15/\$30/\$250 HMO+ (QPOS): <input type="checkbox"/> \$15/\$30/\$250 <input type="checkbox"/> \$20/\$40/\$500 CPOS: <input type="checkbox"/> \$500 90/70 <input type="checkbox"/> \$1,500 70/50 <input type="checkbox"/> \$250 80/60 <input type="checkbox"/> \$1,500 100/50 <input type="checkbox"/> \$500 80/60 <input type="checkbox"/> \$2,500 100/50 <input type="checkbox"/> \$750 80/60 <input type="checkbox"/> \$5,000 100/50 <input type="checkbox"/> \$1,000 80/60 PPO: <input type="checkbox"/> \$500 90/70 <input type="checkbox"/> \$750 80/60 <input type="checkbox"/> \$250 80/60 <input type="checkbox"/> \$1,000 70/50 <input type="checkbox"/> \$500 80/60 <input type="checkbox"/> \$2,000 70/50 PPO Value: <input type="checkbox"/> Value \$1,500 80/50 <input type="checkbox"/> Value Saver \$10,000 100/50 <input type="checkbox"/> Value Limited \$750 50/50 CDHP: <input type="checkbox"/> HSA HDHP \$2,400 100/50 <input type="checkbox"/> HSA HDHP \$3,000 80/50 <input type="checkbox"/> Indemnity \$500 80% <input type="checkbox"/> Out-of-State: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000					B. Dental - Check one (if applicable) (available if offered by employer) Standard Plans: <input type="checkbox"/> Option 1: DMO® <input type="checkbox"/> Option 2: Freedom-of-Choice: <input type="checkbox"/> DMO® or <input type="checkbox"/> PPO <input type="checkbox"/> Option 3: PPO Max 1500 <input type="checkbox"/> Option 4: PPO Max 1000 <input type="checkbox"/> Option 5: PPO 1500 (90th) <input type="checkbox"/> Option 6: DMO® Plan 41 <input type="checkbox"/> Option 7: DMO® Access <input type="checkbox"/> Option 8: Aetna Dental Preventive Care SM PPO Max <input type="checkbox"/> Option 9: PPO Max 2000 <input type="checkbox"/> Out-of-State PPO Voluntary Plans: <input type="checkbox"/> Option V1: DMO® <input type="checkbox"/> Option V2: Freedom-of-Choice: <input type="checkbox"/> DMO® or <input type="checkbox"/> PPO <input type="checkbox"/> Option V3: PPO Max 1500 <input type="checkbox"/> Option V4: DMO® Plan 41 <input type="checkbox"/> Option V5: DMO® Access <input type="checkbox"/> Option V6: Aetna Dental Preventive Care SM PPO Max <input type="checkbox"/> Out-of-State PPO Before today, were you covered under this employer's dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No					C. Life and Disability (available if offered by employer) <input type="checkbox"/> Basic Life / AD&D Ultra™ <input type="checkbox"/> Optional Dependent Life <input type="checkbox"/> Life & Disability Packaged Plan Beneficiary Designation - Full Name (First, Middle, Last) Beneficiary Social Security Number Relationship to Employee		

2. Subscriber Information – Please complete portion ONLY if a recent change.

Last Name, First Name, M.I.				Social Security or ID Number			
Address (P.O. Box not acceptable)			Apt. No.	City, State		ZIP Code	
Home Telephone		Work Telephone		No. of Dependents Including Spouse		Spouse's Social Security or ID Number	
Job Title		Employer Name				No. of Hours Worked Per Week	

3. Subscriber/Family Information – List individuals for whom you are enrolling or adding/changing/removing coverage. Insert additional sheets if necessary. If spouse's last name is different from yours, is he/she a domestic partner? Yes No.

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 Number	Current Patient	Dental Office ID Number (if applicable)	Current Patient
a. Self							<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated		Yes <input type="checkbox"/>		Yes <input type="checkbox"/>
b. Spouse/Domestic Partner			<input type="checkbox"/> Spouse <input type="checkbox"/> Other _____				<input type="checkbox"/> Different Last Name		<input type="checkbox"/>		<input type="checkbox"/>
c. Child			<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____				<input type="checkbox"/> Different Last Name <input type="checkbox"/> Lives at another address <input type="checkbox"/> Full-Time Student (19+) <input type="checkbox"/> Disabled (19+)		<input type="checkbox"/>		<input type="checkbox"/>
d. Child			<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____				<input type="checkbox"/> Different Last Name <input type="checkbox"/> Lives at another address <input type="checkbox"/> Full-Time Student (19+) <input type="checkbox"/> Disabled (19+)		<input type="checkbox"/>		<input type="checkbox"/>
e. Child			<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____				<input type="checkbox"/> Different Last Name <input type="checkbox"/> Lives at another address <input type="checkbox"/> Full-Time Student (19+) <input type="checkbox"/> Disabled (19+)		<input type="checkbox"/>		<input type="checkbox"/>

4. Health History of Members Currently Enrolled* - Please complete the Uniform Employee Health Status Questionnaire, which can be found at www.id.state.az.us/consumerbusiness.html#health.

*- This form is to be completed only for those employees who are requesting to upgrade their benefits.

5. Conditions of Enrollment

1. I understand and agree that this Change of Coverage Application may be transmitted to Aetna or its agent by my employer 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 Change of Coverage Application, including those involving mental health and substance abuse. 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/domestic partner and competent adult dependents and I have obtained their consent to these 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, as is any authorized representative that I may designate, to receive a copy of this authorization upon request and that a photocopy is as valid as the original.

2. Authorizations signed for the purposes of collecting information in connection with this form for an insurance policy, a policy reinstatement or a request for a change in policy benefits shall remain valid for thirty (30) months from the date signed. Authorizations signed for the purposes of collecting information in connection with a claim for benefits shall remain valid for the term of this coverage or for so long as allowed by law. The information, as well as other personal or privileged information, subsequently collected by the insurance institution or agent may, in certain circumstances, be disclosed to third parties without authorization. A right of access and correction exists with respect to all personal information collected. Further disclosures required by **Arizona** law will be furnished to the policyholder upon request. Personal information may be collected from persons other than the individual or individuals proposed for coverage.

3. 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.

6. Authorization

I represent that all information supplied in this form is true and complete. I have read and agree to the Conditions of Enrollment and Authorization on this **Arizona** Group Business Employee Change of Coverage Application Form.

I understand in the event I fail to sign and return 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.

Employee Signature X	Employee E-mail Address (optional)	Date (Mo./Day/Yr.)
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