●Medical ● Dental ● Life Enrollment / Change Request

A. ACTION DESIRED

Enrollment – *Check one*

☐ **New Enrollee / Subscriber** Date of Hire:__________ Effective Date:__________

☐ **Rehire / Reinstatement** Date of Rehire / Reinstatement: _______________

Change – *Check all that apply* **Date of Event:**_______________

☐ **Cancel Coverage for Self** ☐ **Delete Spouse** ☐ **Delete Child**
◇ Other Coverage ◇ Divorce ◇ Overage Dependent ◇ Reduction in Hours
◇ Medicare Eligible ◇ Open Enrollment

☐ **Add Spouse** ☐ **Add Dependent Child** ☐ **Name Change** ☐ **Other**
◇ Marriage ◇ Birth ◇ Open Enrollment ◇ Court Order ◇ Eligibility Period

B. PERSONAL INFORMATION

Employee: Last Name	First Name	Middle Initial	E-Mail:
Residence Address: Apt #	City	State Zip	Home Telephone #: ( ) Alternate Telephone #: ( )

C. MEDICAL BENEFIT CHOICE

☐ AETNA POS II (PPO)

☐ AETNA Select (EPO)

DENTAL BENEFIT CHOICE

☐ AETNA Dental (PPO)

☐ AETNA Dental (DMO)

Please visit AETNA'S website to search for a Doctor or Dentist at: www.aetna.com

List all eligible dependents you wish to ADD or DELETE

MEDICAL	Primary Care Physician ID #: **(Only Required for EPO)**	DENTAL	Primary Care Dentist ID #: **(Only Required for DMO)**	Last Name, First Name, Middle Initial	GENDER	Social Security #	Relationship	Birth Date: Month	Day	Year
☐ Add ☐ Delete		☐ Add ☐ Delete			☐ Male ☐ Female		**SELF**			
☐ Add ☐ Delete		☐ Add ☐ Delete			☐ Male ☐ Female		**SPOUSE**			
							Child(ren)			
☐ Add ☐ Delete		☐ Add ☐ Delete			☐ Male ☐ Female		☐ Natural or Adopted ☐ Step ☐ Other			
☐ Add ☐ Delete		☐ Add ☐ Delete			☐ Male ☐ Female		☐ Natural or Adopted ☐ Step ☐ Other			
☐ Add ☐ Delete		☐ Add ☐ Delete			☐ Male ☐ Female		☐ Natural or Adopted ☐ Step ☐ Other			
☐ Add ☐ Delete		☐ Add ☐ Delete			☐ Male ☐ Female		☐ Natural or Adopted ☐ Step ☐ Other			

To add additional children please use another Enrollment Form.

D. ING Life / LTD Insurance Your EMPLOYER is paying the FULL cost for this coverage. You are automatically enrolled and covered under benefits upon eligibility date according to our plan documents.			
Beneficiary Name	**Beneficiary's Date of Birth**	**Relationship**	**%**
1)			
2)			
3)			
4)			

E. Acknowledgements – Signature Required ONLY if electing Medical / Dental Coverage

I hereby request the group for which I am or may become eligible and authorize deductions from earnings to serve as payments for any required contributions. I agree that my compensation will be reduced by the amount necessary to cover the employee portion if the premium owed for my group health coverage.

My signature below affirms that all information and statements provided on this form are full, complete and true to the best of my knowledge. I understand that misstatements, misrepresentations, or omissions may result in my insurance coverage being voided as of its effective date with no benefits payable.

Employee Signature: ______________________________ Date: ____________________

F. WAIVER OF COVERAGE

Waiver applies to: ☐ **SELF** ☐ Medical ☐ Dental ☐ **SPOUSE** ☐ Medical ☐ Dental ☐ **CHILD(REN)** ☐ Medical ☐ Dental

Reason for waiving coverage (Required only if employee is waiving coverage – Not required if waiving coverage for dependents)

□ Other Group Coverage Carrier Name:______________________ / Group #: ____________________

□ Medicare □ Medi-Cal □ Individual Policy □ Other Reason: ______________________________

Signature (REQUIRED if waiving Health / Medical Coverage)
I understand that by waiving coverage for myself and/or my dependents, I may not be eligible to participate in this plan during this plan year. I further understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I furnish my Employer with a certificate of coverage termination and that I request enrollment within 30 days that the other coverage ends.

In addition, if a new dependent relationship forms as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents provided that I furnish my employer with documents, such as a marriage certificate, birth certificate, adoption certificate and/or court documents and request enrollment within 30 days of the qualifying event.

Employee Signature: ______________________________ **Date:** ____________________