

•Medical • Dental • Vision • Life/AD&D Enrollment / Change Request



A. ACTION DESIRED					
Enrollment – Check one <input type="checkbox"/> New Enrollee Date of Hire: _____ Effective Date: _____ <input type="checkbox"/> Rehire / Reinstatement Date of Rehire / Reinstatement: _____ <input type="checkbox"/> Add/Delete Dependent(s) Effective Date: _____			Change – Check all that apply Date of Event: _____ <input type="checkbox"/> Cancel Coverage for Self <input type="checkbox"/> Delete Spouse <input type="checkbox"/> Delete Child <input type="checkbox"/> Other Coverage <input type="checkbox"/> Divorce <input type="checkbox"/> Overage Dependent <input type="checkbox"/> Reduction in Hours <input type="checkbox"/> Medicare Eligible <input type="checkbox"/> Open Enrollment		
			Change – Check all that apply Date of Event: _____ <input type="checkbox"/> Add Spouse <input type="checkbox"/> Add Dependent Child <input type="checkbox"/> Name Change <input type="checkbox"/> Other <input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Court Order <input type="checkbox"/> Eligibility Period		
B. PERSONAL INFORMATION					
Employee: Last Name		First Name		Middle Initial	
Home Address:			Apt #		City
			State		Zip
			Home Telephone #:		Alternate Telephone #:
			()		()
E-Mail:					
SS #					

C. MEDICAL PLAN OPTION	DENTAL PLAN OPTION	VISION PLAN OPTION	Optum HSA Account (per pay period)
<input type="checkbox"/> AETNA POS II (PPO) <input type="checkbox"/> AETNA SELECT <input type="checkbox"/> AETNA POS II (HSA)	<input type="checkbox"/> AETNA Dental (DPPO) <input type="checkbox"/> AETNA Dental (DHMO)	<input type="checkbox"/> VSP <input type="checkbox"/> VSP (Protec) (Employee Only Coverage)	Please deduct the following amount per payroll: \$ _____ .00 Employee Max: \$132.69 Family Max: \$265.38

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

Please fax this form to (310) 900-5552
 or call (310) 900-5551 for assistance

MEDICAL	Primary Care Physician ID #: <i>(Only Required for Aetna Select)</i>	DENTAL	Primary Care Dentist ID #: <i>(Only Required for DHMO)</i>	VISION	Last Name, First Name, Middle Initial	Gender	Social Security #	Relationship	Birth Date		
									Month	Day	Year
<input type="checkbox"/> Add <input type="checkbox"/> Delete		<input type="checkbox"/> Add <input type="checkbox"/> Delete		<input type="checkbox"/> Add <input type="checkbox"/> Delete		<input type="checkbox"/> M <input type="checkbox"/> F	- -	SELF			
<input type="checkbox"/> Add <input type="checkbox"/> Delete		<input type="checkbox"/> Add <input type="checkbox"/> Delete		<input type="checkbox"/> Add <input type="checkbox"/> Delete		<input type="checkbox"/> M <input type="checkbox"/> F	- -	SPOUSE			
								Child(ren)			
<input type="checkbox"/> Add <input type="checkbox"/> Delete		<input type="checkbox"/> Add <input type="checkbox"/> Delete		<input type="checkbox"/> Add <input type="checkbox"/> Delete		<input type="checkbox"/> M <input type="checkbox"/> F	- -	Child			
<input type="checkbox"/> Add <input type="checkbox"/> Delete		<input type="checkbox"/> Add <input type="checkbox"/> Delete		<input type="checkbox"/> Add <input type="checkbox"/> Delete		<input type="checkbox"/> M <input type="checkbox"/> F	- -	Child			
<input type="checkbox"/> Add <input type="checkbox"/> Delete		<input type="checkbox"/> Add <input type="checkbox"/> Delete		<input type="checkbox"/> Add <input type="checkbox"/> Delete		<input type="checkbox"/> M <input type="checkbox"/> F	- -	Child			
<input type="checkbox"/> Add <input type="checkbox"/> Delete		<input type="checkbox"/> Add <input type="checkbox"/> Delete		<input type="checkbox"/> Add <input type="checkbox"/> Delete		<input type="checkbox"/> M <input type="checkbox"/> F	- -	Child			

To add additional children please use another Enrollment Form.

D.

Life, AD&D & LTD Insurance

TAP 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 / Vision 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 Vision **SPOUSE** Medical Dental Vision **CHILD(REN)** Medical Dental Vision

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:** _____