Employee Enrollment/Change Request
Texas Health Aetna

HMO, POS, Open Access HMO and Open Access HMO Option plans are underwritten by Texas Health + Aetna Health Plan Inc. (referred to as "Texas Health Aetna").

Instructions: *Refer to the instructions before completing this form. You must complete this application in full or it will be returned to you, and that can delay its processing. You alone are responsible for its accuracy and completeness.*

Control	Suffix	Account	Plan number
Group number			Class code

Employer group information (To be completed by employer)

Group / employer name – full name of business or organization

A. Type of activity – Employee completes sections A – D. ***Please print clearly.***

Enrollment
- ☐ New enrollee / subscriber

Effective date: ____/____/____

Date of hire: ____/____/____

Change – *Check all that apply.*
- ☐ Add spouse
- ☐ Add child
- ☐ Name change
- ☐ Other ____
- ☐ Change plan: ____
- ☐ Control/Suffix/Account/Plan: ____

Date of event: ____/____/____

Reason: ____

Remove or terminate – *Check all that apply.*
- ☐ Remove spouse
- ☐ Remove child
- ☐ Employee withdrawal / termination

Effective date: ____/____/____

Reason: ____

Continuation of coverage, i.e., COBRA, State
Not all options are available. Contact employer for available options.

Coverage for: ☐ Employee ☐ Dependents

Length of continuation (months):
- ☐ 18 ☐ 36 ☐ Other ____
- ☐ 29 – Attach disability determination from the Social Security Administration

Date of loss of coverage: ____/____/____

Date of qualifying event: ____/____/____

Continuation of coverage expiration date: ____/____/____

B. Employee information

Social Security number	Last name, first name, middle initial		Home telephone
Home address	Apt. Number	City, state	ZIP code
Employer name			Work telephone
Work address		City, state	ZIP code

Subscriber primary language (other than English)
Primer Idioma del suscriptor (que no sea el Ingles)
What is your primary Language? ¿Cuál es su primer idioma?
____

Subscriber disability
Do you have a disability which affects your ability to communicate or read?
☐ Yes ☐ No
If Yes, please indicate the nature of your disability. ____

C. Plan options – Your selection(s) must be offered by your employer.

- ☐ HMO
- ☐ Open Access HMO
- ☐ POS
- ☐ Open Access HMO Option

These plans are underwritten by Texas Health + Aetna Health Plan Inc.

Indicate plan name

Primary copay
- ☐ $5 ☐ $10
- ☐ $15 ☐ Other $ ____

While the Federal Patient Protection and Affordable Care Act generally mandates coverage of children up to age 26, your plan may allow coverage up to age 26 and beyond. Please refer to your plan documents or contact your benefits administrator.

D. Individuals covered - ***List individuals for whom you are enrolling or adding, changing or removing coverage. Add more sheets if needed.***

1	☐ Add ☐ Change ☐ Remove	**Employee name** (Last, first, middle initial)	Sex (M/F)	**Birthdate** (MM/DD/YYYY) / /	**Social Security number**
Primary medical office ID number (if applicable)	Current patient **Yes** ☐	Ob / Gyn office ID number (if applicable)	Current patient **Yes** ☐		
2	☐ Add ☐ Change ☐ Remove	**Spouse name** (Last, first, middle initial)	Sex (M/F)	**Birthdate** (MM/DD/YYYY) / /	**Social Security number**
Primary medical office ID number (if applicable)	Current patient **Yes** ☐	Ob / Gyn office ID number (if applicable)	Current patient **Yes** ☐		
3	☐ Add ☐ Change ☐ Remove	**Child name** (Last, first, middle initial)	Sex (M/F)	**Birthdate** (MM/DD/YYYY) / /	
Social Security number (if dependent has no SSN, write "None")	Handicapped **Yes** ☐	Primary medical office ID number (if applicable)	Current patient **Yes** ☐		
4	☐ Add ☐ Change ☐ Remove	**Child name** (Last, first, middle initial)	Sex (M/F)	**Birthdate** (MM/DD/YYYY) / /	
Social Security number (if dependent has no SSN, write "None")	Handicapped **Yes** ☐	Primary medical office ID number (if applicable)	Current patient **Yes** ☐		
5	☐ Add ☐ Change ☐ Remove	**Child name** (Last, first, middle initial)	Sex (M/F)	**Birthdate** (MM/DD/YYYY) / /	
Social Security number (if dependent has no SSN, write "None")	Handicapped **Yes** ☐	Primary medical office ID number (if applicable)	Current patient **Yes** ☐		
6	☐ Add ☐ Change ☐ Remove	**Child name** (Last, first, middle initial)	Sex (M/F)	**Birthdate** (MM/DD/YYYY) / /	
Social Security number (if dependent has no SSN, write "None")	Handicapped **Yes** ☐	Primary medical office ID number (if applicable)	Current patient **Yes** ☐		

1. Does any dependent listed above live at a different address than the employee? ☐ Yes ☐ No If **yes**, who and what address? Briefly explain circumstances.

2. Is your spouse employed? ☐ Yes ☐ No If **yes**, provide name and address of spouse's employer.

Conditions of enrollment

Applicant acknowledgments and agreements

On behalf of myself and the dependents listed in section D, I agree to or with the following:

1. I acknowledge that by enrolling in a medical plan, coverage is underwritten or administered by Texas Health + Aetna Health Plan Inc. (referred to as "Texas Health Aetna").
2. I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments as required for coverage.
3. I understand and agree that this Enrollment / Change Request may be transmitted to Texas Health Aetna or its agent by my employer or its agent. I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("providers") to give Texas Health Aetna or its agent information concerning the medical history, services or treatment provided to anyone listed on this Enrollment / Change Request form, including those involving mental health, substance abuse and HIV / AIDS. I further authorize Texas Health 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. This authorization is applicable to the Texas Health Aetna company underwriting coverage(s) for the product checked in section C on page 1. I have discussed the terms of this authorization with my spouse and competent adult dependents and I have obtained their consent to those terms. I understand that this authorization is provided under state law and that it is not an "authorization" within the meaning of the federal Health Insurance Portability and Accountability Act. This authorization will remain valid for the term of the coverage and so long thereafter as allowed by law. I understand that I am or my authorized representative is entitled to a copy of this authorization upon request and that a photocopy is as valid as the original.
4. The plan documents (Schedule of Benefits, Group Agreement, Group Evidence of Coverage) 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.
5. As a condition to HMO benefits, I understand and agree that (with the exception of direct access services and emergency procedures as defined in the plan documents) all services, in order to be covered by the Texas Health Aetna HMO, must be performed either by a participating primary care physician, or by the participating specialist, hospital, pharmacy, dentist, or other provider as authorized by a prior referral form from a participating primary care physician.

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 intentional misrepresentation of material fact 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.

Employee signature

If you wish to receive documents online, please visit your secure member account at https://www.texashealthaetna.com

I certify that all information supplied in this form is true and complete to the best of my knowledge and / or belief. I have read and agree to the Conditions of enrollment on this Enrollment / Change Request form.

Employee signature - required	*Date (Month/Day/Year)*	*Employee email*	*Primary language spoken*
X	/ /		

Instructions

Employer - Complete the **Employer group information** at the top of page 1.

Employee – Complete sections A – D. Additional dependent and / or other information may be provided on a separate sheet of paper. All attachments must be signed and dated.

Section A – Type of activity:

- Check box(es) indicating reason(s) for submitting this Enrollment / Change Request.
- Provide Effective date(s) & Date of event(s) where requested.

Section B – Employee information: Complete **all** information in order for your Enrollment / Change Request to be processed.

Section C – Plan options:

- Your selection(s) must be offered by your employer.
- Where applicable, indicate Plan option name and check *one* Primary copay.

Section D – Individuals covered:

- Check box to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the names(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, and Social Security number for each individual listed.
- If a dependent is Handicapped and financially dependent, check yes and provide proof of handicapped status from the attending physician.
- Primary medical office ID number (if applicable): Locate the office ID number for the primary care physician from the appropriate provider directory or from the online provider directory.
  - If you are a current patient, please check the **Yes** box under Current patient.
- Primary Ob / Gyn office ID number (if applicable): Locate the office ID number for the obstetrician or gynecologist from the appropriate provider directory or from the online provider directory.
  - NOTE: You are not required to select an obstetrician or gynecologist, but may instead receive obstetrical or gynecologist services from your primary care physician or primary care provider. You have the right at all times to select or change a selected obstetrician or gynecologist. An HMO may limit your request to change an obstetrician or gynecologist to no more than four changes in any 12-month period.
  - If you are a current patient, please check the **Yes** box under Current patient.

Conditions of enrollment and Misrepresentation – Employee signature:

- Employee must sign and date the Enrollment / Change Request for new enrollments or coverage changes to be processed.
- Read the Conditions of enrollment.