# Employee Enrollment/Change Request
## 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**

| |
|---|
| **Employer name – full name of business or organization** |
| **Employer address (street, city, state, ZIP code) – primary location of business or organization** |

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

| **Enrollment** – *Check one.* | **Change** – *Check all that apply.* | **Remove or terminate** – *Check all that apply.* | **Continuation of coverage, i.e., COBRA, State** *Not all options are available. Contact employer for available options.* |
|---|---|---|---|
| ☐ New enrollee / subscriber<br>**Effective date:** ____/____/____<br>**Date of hire:** ____/____/____ | ☐ Add spouse<br>☐ Add dependent child<br>☐ Name change<br>☐ Other _____<br>☐ Control/Suffix/Account/Plan: _____<br>**Date of event:** ____/____/____<br>**Reason:** _____ | ☐ Remove spouse<br>☐ Remove dependent child<br>☐ Employee withdrawal / termination<br>☐ Cancel coverage<br>**Effective date:** ____/____/____<br>**Reason:** _____ | **Coverage for:** ☐ Employee ☐ Dependents<br>**Length of continuation (months):**<br>☐ 18 ☐ 36 ☐ Other _____<br>☐ 29 – Attach disability determination from the Social Security Administration<br>**Date of loss of coverage:** ____/____/____<br>**Date of qualifying event:** ____/____/____<br>**Continuation of coverage expiration date:** ____/____/____ |
| ☐ Rehire / reinstatement<br>**Date of rehire / reinstatement** ____/____/____ | | | |

**B. Employee information**

| **Social Security number** | Last name, first name, middle initial | | Home telephone | Work telephone |
|---|---|---|---|---|
| Employee status ☐ Active ☐ Retired | Home address | Apt. Number | City, state | ZIP code |

**C. Plan options – Your selection must be offered by your employer.**

| ***Check one:*** | | | **Indicate plan name** |
|---|---|---|---|
| | ☐ PPO | ☐ Network Only Plus | |
| | ☐ Managed Plus | ☐ Open Access Network Only Plus | |
| | ☐ Open Access Managed Plus | | |

While the Federal Patient Protection and Affordable Care Act generally mandates coverage of dependent children up to age 26, your plan may allow coverage beyond age 26. 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.***

☐ **Check this box if you are refusing coverage for your dependents.**

| | | | | | |
|---|---|---|---|---|---|
| **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** ☐ |
| **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** ☐ |
| **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** ☐ |

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

## Conditions of enrollment

**Applicant acknowledgments and agreements**

On behalf of myself and the dependents listed on pages 1 and 2, 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 Insurance Company (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. 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 receive a copy of this authorization upon request and that a photocopy is as valid as the original.
4. 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.

## 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 may commit 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. I have read and agree to the Conditions of enrollment and Misrepresentation on this Employee 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. 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) and 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 must be offered by your employer.

**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.
- 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.

**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.