aetna®

# Life Enrollment/Change Request

**Aetna Life Insurance Company**

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Refer to the instructions on Page 4 when completing this form.

| Control | Suffix | Account | Plan Number |
|---|---|---|---|
| | | | |

## A. Employer Group Information

| Employer Name - Full Name of Business or Organization | SFO | Claim Office |
|---|---|---|
| | | |

| Employer Address (Street, City, State, ZIP Code) - Primary Location of Business or Organization | Customer Code (Optional) |
|---|---|
| | |

## B. Employee Information – *Please Print all Information*

| Employee Social Security Number | Employee Name | Employee Annual Earnings |
|---|---|---|
| | | $ |

| Employee Home Address (Number, Street, Apt. No., City, State, ZIP Code) | Birthdate (MM/DD/YYYY) | Sex |
|---|---|---|
| | / / | ☐ Male ☐ Female |

| Telephone Numbers | Occupation/Title | Work State |
|---|---|---|
| Home ( ) Work ( ) | | |

## C. Declination/Waiver of Coverage - To be completed if coverage is declined or refused by employee.

| | |
|---|---|
| I acknowledge I have been given the right to apply for this coverage, however, I am electing not to enroll. | *Please sign here ONLY IF YOU ARE DECLINING coverage.* Employee Signature X _____ Date _____ |

## D. Enrollment/Change Information

1. **Enrollment** - *Check one.*

☐ New Employee
☐ Rehire/Reinstatement
☐ Late Applicant
☐ Retiree

Effective Date (MM/DD/YYYY) _____

Date of Hire/Rehire (MM/DD/YYYY) _____

☐ Check here if enrollment is due to a Family Status change.
☐ Check here if enrollment is due to an Annual Enrollment period.

2. **Change applies to:**

☐ Employee
☐ Spouse
☐ Child(ren)

Effective Date (MM/DD/YYYY) _____

☐ Check here if enrollment is due to a Family Status change.
☐ Check here if enrollment is due to an Annual Enrollment period.

## E. Employee Plan Options and Coverage Amounts

Based on the requirements of your Plan, you may be required to submit evidence of good health.

1. ***Employee must be enrolled for employee coverage in order to enroll spouse/child(ren) for coverage.***

☐ Enroll ☐ Change Plan ☐ Increase/Buy-up ☐ Decrease
☐ Cancel ☐ Terminate ☐ Other Changes (Provide details in Section H, Special Remarks.)

2.

☐ Supplemental Life _____
☐ Supplemental AD&D _____

Tobacco Use: Have you used tobacco products (cigarettes, cigars, pipe, chewing tobacco) within the past 12 months? ☐ Yes ☐ No

3. **Beneficiary Designation (Life Insurance ONLY)** Spouse and Child(ren) coverage Beneficiary is always the Employee.

If additional beneficiaries, use Section H, Special Remarks. * If naming more than one Beneficiary, percentages must equal 100%.

| Full Beneficiary Name (First, Middle, Last) | Social Security Number of Beneficiary | Relationship to Employee | % of Benefit * |
|---|---|---|---|
| ☒ Primary | | | |
| ☐ Primary ☐ Contingent | | | |
| ☐ Primary ☐ Contingent | | | |
| ☐ Primary ☐ Contingent | | | |

**Please make a copy for your records.** **Visit us at www.aetna.com**

## F. Spouse Plan Options and Coverage Amounts – *Please Print all Information.*

☐ Check this box if you are not electing spouse coverage.

Based on the requirements of your Plan, your spouse may be required to submit evidence of good health.

| 1. Spouse Name | Relation. Code | Sex M ☐ F ☐ | Birthdate (MM/DD/YYYY) | Social Security Number |
|---|---|---|---|---|
| | | | / / | |

2. ***Employee must be enrolled for employee coverage in order to enroll spouse for coverage.***

☐ Enroll ☐ Change Plan ☐ Increase/Buy-up ☐ Decrease

☐ Cancel ☐ Other Changes (Provide details in Section H, Special Remarks.)

3.

☐ Supplemental Dependent Life – Spouse _____

Tobacco Use: Has your spouse used tobacco products (cigarettes, cigars, pipe, chewing tobacco) within the past 12 months? ☐ Yes ☐ No

## G. Child Plan Options and Coverage Amounts – *Please Print all Information.*

☐ Check this box if you are not electing child(ren) coverage.

Based on the requirements of your Plan, you may be required to submit evidence of good health for your child(ren).

| 1. Child(ren) Name (First, Middle Initial, Last) (Explain difference in last names in Section H, Special Remarks.) | Relation. Code | Sex M F | Birthdate MM DD YYYY | Social Security Number (If child has no SSN, write "None") | Full Time Student |
|---|---|---|---|---|---|
| | | ☐ ☐ | / / | | Yes ☐ |
| | | ☐ ☐ | / / | | ☐ |
| | | ☐ ☐ | / / | | ☐ |
| | | ☐ ☐ | / / | | ☐ |
| | | ☐ ☐ | / / | | ☐ |

**2.** ***Employee must be enrolled for employee coverage in order to enroll child(ren) for coverage.***

☐ Enroll ☐ Change Plan ☐ Increase/Buy-up ☐ Decrease

☐ Cancel – Are other child(ren) still covered under this plan? ☐ Yes ☐ No ☐ Other Changes (Provide details in Section H, Special Remarks.)

3.

☐ Supplemental Dependent Life – Child _____

## H. Special Remarks - Use this space to provide clarification and/or additional information for Sections **E** through **G**. ***Please Print Clearly.***

## I. Certification - Signatures Required

*Employee's E-mail Address:*

My signature below signifies my agreement with the statements and authorization in the Certification and Authorization section and the Misrepresentation section on Page 3 of this form.

| **Employee Signature** *(Required)* | **Date** | **Employer Signature** *(Required)* | **Date** |
|---|---|---|---|
| **X** | | **X** | |

## Certification and Authorization

1. I certify that all information on this form is true and complete to the best of my knowledge and belief. I understand that this insurance is subject to all of the terms of the Plan of Insurance contained in the group policy and summarized in the announcement materials provided me and the certificate issued to me.
2. I understand that the effective date of insurance for myself or for any of my dependents is subject to my being actively at work on that date and that the effective date of insurance for any of my dependents is also subject to the dependent health condition requirements of the Plan. Further, I understand that any insurance subject to evidence of good health or medical information will not become effective until Aetna gives its written consent.
3. I understand that, in the event I fail to sign this form within 31 days of the effective date of eligibility or that for any reason Aetna does not receive notice of the Enrollment/Change Request within a reasonable time following the date I was eligible to enroll or change my coverage, my and my dependents' eligibility may be affected.
4. I request my employer to arrange for the issuance of Group Life Coverage for which I am or may become eligible and authorize deductions of the required contributions from my earnings.

## 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 materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Attention Arkansas, Louisiana, Rhode Island and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention Ohio and Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Attention California Residents: For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Attention Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Attention Florida Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

Attention Maine and Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Attention Maryland Residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Attention New York Residents, the following statement applies only to your AD&D and Disability coverage(s): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Attention North Carolina Residents: 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 materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties.

Attention Oklahoma Residents: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Attention Oregon Residents: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Puerto Rico Residents: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Attention Vermont Residents: 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 materially false information 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.

Attention Virginia Residents: 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 materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Attention Washington Residents: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

## Instructions

### Section A - Employer Group Information

- If not preprinted, provide the complete Control, Suffix, Account Number and Plan Number.
- If not preprinted, provide Employer name and address.

### Section B – Employee Information

- Complete **all** information requested. Incomplete or missing information may result in delays in the processing of your Enrollment/Change Request.
- Birthdate should include four-digit year of birth.

### Section C - Declination of Coverage

- If you are waiving coverage complete only Sections A, B and C.
- Note: Your employer's plan may require the employee to be enrolled for employee coverage in order to enroll the spouse/child(ren) for coverage. If this requirement is part of your employer's plan, the Enrollment/Change Request form will state this in Sections E1, F2 and G2.

### Section D - Enrollment/Change Information

- Check all applicable boxes in Section D1.
- Complete the Effective Date and Date of Hire/Rehire.
- If you are making a change, check all applicable boxes and complete the Effective Date in Section D2.

### Section E - Employee Plan Options and Coverage Amounts

- Check the box applicable to the action you are initiating in Section E1.
- Check the box(es) applicable to the benefit(s) you wish to enroll/change and provide the coverage amount you are requesting in Section E2.
  - Note: Evidence of Good Health may be required. Please refer to your plan documents for details.
- If applicable, a Tobacco Use statement will be included in Section E2. This question must be completed.
- Complete the Beneficiary Designation in Section E3 only if your employer's plan includes a Life Insurance benefit and you are electing this Life Insurance benefit.
  - Provide the full legal name of your beneficiary(ies), Social Security Number, relationship to the employee and the percentage of your benefit that will be paid to the designated beneficiary(ies) in the event of your death. Dollars and cents should not be specified. When added together, the sum of the percentages going to two or more named beneficiaries should not be more or less than 100%. Contingent beneficiary(ies) will only receive proceeds if all primary beneficiaries have predeceased the employee.

### Section F - Spouse Plan Options and Coverage Amounts

- If enrolling/changing spouse coverage, provide the full name of your spouse and all other information requested in Section F1.
  - Relationship Code - Select one: H=Husband, W=Wife, N=Divorced Spouse, Y=Sponsored Male, X=Sponsored Female.
  - Birthdate should include four-digit year of birth.
- Check the box applicable to the action you are initiating in Section F2.
- Check the box(es) applicable to the spousal benefit(s) you wish to enroll/change and provide the coverage amount you are requesting in Section F3.
  - Note: Evidence of Good Health may be required. Please refer to your plan documents for details.
- If applicable, a Tobacco Use statement will be included in Section F3. This question must be completed for your spouse.

### Section G - Child Plan Options and Coverage Amounts

- If enrolling/changing child coverage, provide the full name(s) of your dependent child(ren) and all other information requested in Section G1.
  - Relationship Code - Select one: S=Son, D=Daughter. If the dependent child(ren) is not your biological or legally adopted child, please indicate relationship to employee in Section H, Special Remarks.
  - Birthdate should include four-digit year of birth.
  - If a dependent child(ren) is a full time student, be sure to check "Yes." Refer to your plan documents for plan definition.
- Check the box applicable to the action you are initiating in Section G2.
- Check the box(es) applicable to the child benefit(s) you wish to enroll/change and provide the coverage amount you are requesting in Section G3.
  - Note: Evidence of Good Health may be required. Please refer to your plan documents for details.

### Section H - Special Remarks

- Use this space to provide clarification and/or additional information if needed.
- Please note: Additional information provided by Aetna or your employer may appear in this space.

### Section I - Certification (Signature Required)

- Read the Certification and Authorization section and the Misrepresentation section on Page 3 prior to signing the form.
- Sign and date the form.
- Please make a copy of this form for your records.