Enrollment/Change Request
Aetna U.S. Healthcare™ of Illinois Inc.

Group Name

Aetna U.S. Healthcare ID No.

Group Number (HMO, USAccess and QPOS Only)

Please read instructions on reverse side before completing this form.
Print clearly.

1. Plan Option (Check One)

☐ HMO ☐ USAccess® ☐ QPOS®

____
(Please Indicate Plan Name)

Primary Co-pay: ☐ $0 ☐ $2 ☐ $5 ☐ $10 ☐ $15 ☐ Other ______

Individual Deductible Amount: (*Complete for QPOS Plans Only*)
☐ $100 ☐ $200 ☐ $300 ☐ $400 ☐ $500 ☐ $750 ☐ $1,000
☐ Other ______________

2. Employee Information

Last Name, First Name, M.I.		Social Security Number
Home Address		Apartment Number
City, State	Zip Code	Home Telephone ( )
Employer Name		Work Telephone ( )
Work Address	Zip Code	Date of Hire

3. Type of Activity

☐ New Subscriber Effective Date ______________

☐ Add/Remove Spouse*
Reason ______________
Date of Event ______________

☐ Add/Remove a Dependent Child*
Reason ______________
Date of Event ______________

☐ Name Change From ______________
To______________
Date of Event______________

☐ Change Plan To ______________

Date of Event ______________

☐ Add/Change Primary Office*

☐ Add/Change Primary Dentist*

☐ Withdrawal/Termination (Complete Section 8 Below)

* *Complete Sections 4 & 5 Below*

4.

4.	No.	Add	Remove	Last Name, First Name, M.I.	Sex M	Sex F	Date of Birth MM DD YYYY	Social Security No.
Employee	a.	☐	☐		☐	☐	/ /	
Spouse	b.	☐	☐		☐	☐	/ /	
Children	c.	☐	☐		☐	☐	/ /	
*Attach sheet to list additional children	d.	☐	☐		☐	☐	/ /	
*Attach proof if full-time	e.	☐	☐		☐	☐	/ /	
college student	f.	☐	☐		☐	☐	/ /	

5.

5.	Change	Primary Office No.	Dentist Office No. (If applicable)
a.	☐		
b.	☐		
c.	☐		
d.	☐		
e.	☐		
f.	☐		

6. Other Insurance

Is your Spouse Employed? ☐ Yes ☐ No

If Yes, please give name and address of spouse's employer.

Does your spouse have health Insurance? ☐ Yes ☐ No

If Yes, please give name and policy number of insurance carrier or other HMO.

If Yes, who is covered by this policy? ☐ Yourself ☐ Yourself/Spouse ☐ Spouse Only ☐ Entire Family

7. Dependent Information

Do any of the dependents listed in Section 4 live at another address? ☐ Yes ☐ No

If Yes, who and at what address?

Explain the circumstances.

If any dependent's last name is different from yours, explain the circumstances.

8. Withdrawal From Plan

☐ No Longer in Group Date of Withdrawal ______________
Note: For COBRA information - See your employer.

☐ Individual Conversion - Bill me at Home
(prescription and dental benefits are not convertible)

☐ I Decline Nongroup Coverage

9. Employee Signature

If you have any questions concerning the benefits and services that are provided by or excluded under this Agreement, please contact a Member Services representative before signing this form.

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the reverse side of the employee copy of this application.

Subscriber ______________ **Date** ______________ **E-mail Address** ______________

Employee copy may be used as a temporary ID card for 30 days from the effective date if authorized by employer. Coverage must be verified with Aetna U.S. Healthcare prior to visiting a specialist or admission to a hospital.

10. Employer Verification

Signature	Title	Date

GR-67603-13 (7-99)

Complete in Triplicate: Aetna U.S. Healthcare - Copy 1; Employer - Copy 2; Employee - Copy 3 - visit us at www.aetnaushc.com

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Enrollment/Change Request Instructions

To Enroll: Complete all sections, except Section 8

To Make Changes: ***For all changes -*** complete Sections 2, 3, 9 and 10. Depending on the Type of Activity box(es) selected, complete the corresponding applicable sections. A Withdrawal/Termination also requires completion of Section 8.

Section 1 Check one Plan Option box, indicate Plan Option Name (where applicable) and check one Primary Co-pay and/or Individual Deductible Amount (if applicable).

Section 2 Complete **all** information in order for your application to be processed.

Section 3 Check box(es) indicating reason(s) for submitting form. Provide Effective Date/Date of Event and Reason (where requested).

Section 4 Print your full name along with the name(s) of your dependent(s), if applicable. Indicate Sex, Date of Birth, and Social Security Number for each individual listed. If a dependent is a full-time college student, you **must** attach a current course schedule or a letter from the school confirming full-time student status (12 or more credits). To indicate whether you are Adding or Removing self and/or dependents, check the appropriate Add or Remove boxes.

Section 5 From the appropriate provider directory, locate the office number for a primary care physician and/or dentist (if applicable). Indicate office number selection(s) on form. Check the change block **only** if you are a current member and are changing providers.

Sections 6 & 7 These sections must be completed for all new enrollments or coverage changes.

Section 8 Complete this section **only** if Withdrawing/Terminating from the plan.

Sections 9 & 10 Complete these sections for all new enrollments or coverage changes. Employee and Employer **must** sign and date the application in order for it to be processed.

Conditions of Enrollment

Applicant Acknowledgments and Agreements

On behalf of myself and the dependents listed on the reverse side, I agree to or with the following:

1. Applicant acknowledges that by enrolling in an Aetna U.S. Healthcare plan, coverage is provided by Aetna U.S. Healthcare of Illinois Inc. and/or an affiliated insurance company (Aetna Life Insurance Company, Corporate Health Insurance™ Company or U.S. Health Insurance Company).
2. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. Your employer is hereby authorized to withhold payments from your wages as appropriate.
3. As a condition of coverage, you understand and agree that (with the exception of emergency procedures and certain direct access services as defined in the plan documents) all services, in order to be covered by Aetna U.S. Healthcare, 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 referral from a participating primary care physician*.
4. You agree to make copayments, as provided for in your plan documents, directly to providers of health care.
5. Aetna U.S. Healthcare (including its affiliates and authorized agents, collectively “Aetna U.S. Healthcare”) and participating network providers require access to member medical information for a number of purposes, including claims payment and fraud prevention; preventive health, early detection and disease management programs; coordination of patient care; quality improvement/management/assessment; utilization review and management; fulfilling state and federal requirements; HEDIS and similar data collection and reporting; accreditation by the National Committee for Quality Assurance and other accreditation organizations; and statistical research. Accordingly, you authorize the sharing of member medical information about yourself and your dependents between Aetna U.S. Healthcare and any hospital, physician, or other health care provider or health delivery system as Aetna U.S. Healthcare and such participating providers may require. Please be assured that it is Aetna U.S. Healthcare's policy to protect the confidentiality of your confidential medical information to the full extent required by the law. I know that I, or an individual entitled to act on my behalf, am entitled to receive a copy of this authorization upon request and agree that a photocopy is as valid as the original.
6. 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 HMO plan.
7. You authorize the substitution of generic pharmaceuticals for the brand-name products, as provided by law, for prescriptions filled under any pharmacy benefit rider.
8. You understand that this coverage will remain in effect until your employer's next open-enrollment period regardless of the continued availability of a particular primary care physician or other health care provider.
9. You acknowledge that Aetna U.S. Healthcare's participating providers, including all participating primary care physicians, are independent contractors and are neither agents nor employees of Aetna U.S. Healthcare.

Your enrollment in Aetna U.S. Healthcare and accessing of your benefits signifies your agreement to these conditions, which are subject to change.

* *Some services may require prior authorization from Aetna U.S. Healthcare.*

Misrepresentation

10. 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.