



UTAH SMALL EMPLOYER HEALTH INSURANCE APPLICATION

OFFICE USE ONLY
Policy / Group No.
Effective Date
PEC
New Hire Waiting Period

REASON FOR ENROLLMENT (mark all that apply)		
<input type="checkbox"/> New Group	<input type="checkbox"/> Newborn*	<input type="checkbox"/> Loss of Coverage*
<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Marriage*	<input type="checkbox"/> Court Order*
<input type="checkbox"/> New Hire*	<input type="checkbox"/> Divorce*	<input type="checkbox"/> Other:
<input type="checkbox"/> New Application	<input type="checkbox"/> Re-apply	<input type="checkbox"/> Dependent Addition
* Date of Event		
<input type="checkbox"/> COBRA / Utah mini-COBRA / Alternative Coverage for:		
<input type="checkbox"/> Employee <input type="checkbox"/> Dependent Employer Name:		
Length of COBRA continuation coverage: <input type="checkbox"/> 18 mos. <input type="checkbox"/> 36 mos. Other:		
Original Qualifying Event Date:	Qualifying Event Date:	Date of Event:

COVERAGE REQUESTED						
Coverage	Self	Spouse	Child(ren)	COBRA	Utah mini-COBRA	Alternative Coverage
Medical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A. EMPLOYER INFORMATION

Employer _____ Hire Date _____ Rehire Date _____
 Location _____ Is this a division? Yes* No *If "Yes," name of parent company _____

B. ENROLLEE INFORMATION

Name (Last) _____ (First) _____ (MI) _____ Job Title _____ Hrs/Week _____
 Marital Status Legally Married Single Divorced Widowed Domestic Partner
 Address _____ Apt. _____ City _____ State _____ Zip _____
 Home (or other) Phone (_____) _____ Business Phone (_____) _____
 Spouse's Employer _____ Spouse's Business (or other) Phone (_____) _____
 Driver's License Number: _____ Email Address: _____

C. ENROLLING SUBSCRIBER / SPOUSE / DEPENDENTS (attach separate sheet if necessary)

In the section below, list yourself and all eligible family members to be included under coverage.

	Social Security #	Name (Last, First, MI)	Date of Birth	Age	M/F	Weight	Height	Medical Coverage	Rx Coverage	HICN
Employee						lbs.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Spouse						lbs.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent						lbs.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent						lbs.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent						lbs.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent						lbs.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Eligible family members include spouse, natural child, stepchild, adopted child, child placed for adoption, and child for whom you are appointed as legal guardian by the court. To be eligible for coverage, children must be under the age of 26, unmarried, and dependent upon you for 50 percent of their financial support. (Financial dependency is not required for court-ordered dependent coverage.) Any dependent not listed will not be considered for coverage.

D. WAIVER OF COVERAGE

- Complete this section for yourself (if waiving) and/or any of your eligible dependents for whom you are waiving coverage. You may not enroll dependents if you are waiving (except children subject to a Qualified Medical Child Support Order).
- If you decline enrollment in this plan for yourself and/or any of your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll the omitted individual(s) in this plan, provided that you request enrollment within 30 days after the other coverage of the individual(s) ends. ("Decline enrollment" includes omission of the individual from this application.) In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption (the **Special Enrollment Period**).
- Please complete type of insurance coverage for the employee and all eligible members who have other health insurance coverage by completing type of insurance [group, individual or other (Medicare, Medicaid, V.A., H.I.P., etc.)]
- All eligible family members must be listed in either Enrolling or Waiving Members section.

Names of persons waiving coverage. Include last name if different from enrollee. No nicknames, please.	Birth Date MM/DD/YYYY	Other Health Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Insurance		Insurance Carrier Name	Reason for Waiver
			Group	Individual		
Employee:		<input type="checkbox"/> Yes <input type="checkbox"/> No				
Spouse:		<input type="checkbox"/> Yes <input type="checkbox"/> No				
Children:		<input type="checkbox"/> Yes <input type="checkbox"/> No				
		<input type="checkbox"/> Yes <input type="checkbox"/> No				
		<input type="checkbox"/> Yes <input type="checkbox"/> No				

E. CURRENT/PRIOR COVERAGE INFORMATION

Please indicate for EACH person listed on this application any health insurance coverage (including Medicare or Medicaid) in effect within 24 months prior to the proposed effective date of this coverage. Each person applying for coverage must be listed below. If no health insurance coverage was in effect within the past 24 months, please indicate NONE. If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation that shows who is responsible for the dependent(s)' health care insurance so that the carrier can determine whose coverage is Primary.

Enrolling Individual's Name (Non-Medicare)	Insurance Carrier (Including policyholder name, insurer name and phone number)	Date of Coverage Month/Day/Year		Will the individual continue this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Coverage (Check all that apply) <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
		From	To		
1.				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
2.				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
3.				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
4.				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
5.				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
6.				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical

MEDICARE: If you or any family members listed on this application have Medicare, is coverage Part A Part B Part D and please complete the following information. **Note: Please submit a copy of your Medicare ID card with this application.**

Enrolling Individual	Effective Date / /	Medicare Number (please include alpha prefix)	Reason for Medicare Entitlement: <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD <input type="checkbox"/> Dual Enrollment
Enrolling Individual	Effective Date / /	Medicare Number (please include alpha prefix)	Reason for Medicare Entitlement: <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD <input type="checkbox"/> Dual Enrollment

Note: If you have had health care coverage within the last 63 days, your Pre-Existing Condition (PEC) waiting period limitation may be partially or completely waived. To determine if this applies to you, you must provide proof of prior coverage, such as a Certificate of Creditable Coverage from your previous carrier. Submission of prior coverage information does not automatically waive any PEC limitation. However, you will be subject to an automatic PEC Waiting Period of up to 12 months until we receive evidence of prior coverage.

F. DISABILITY INFORMATION

Are you or any dependent(s) disabled? Yes No If yes, indicate first and last name(s). _____

Reason for disability: _____

Is the disabled dependent unable to perform routine daily functions for two weeks or more? Yes No

Have you or any dependent(s) filed workers' compensation claims or disability claims within the last five years? Yes No

If so, what is the status of the claims? _____

G. HEALTH STATEMENT

IF ANY OF THE BELOW CONDITIONS OR QUESTIONS ARE CHECKED "YES" PROVIDE DETAILS IN SECTIONS H. & I. ON THE FOLLOWING PAGE. The federal Genetic Information Nondiscrimination Act prohibits health issuers from requesting, requiring, purchasing, or collecting "genetic information" for underwriting purposes. "Genetic information" includes your genetic tests, the genetic tests of your family members, and the manifestation of a disease or disorder in family members not covered by the policy. Genetic information can also include requests for, or receipt of, genetic services, or participation in clinical research which includes genetic services. **Do not report genetic information on this form.** However, information about manifested diseases or conditions of anyone applying for coverage is not considered genetic information and is to be reported on this form, even if the disease or condition is caused by or associated with genetics.

EACH QUESTION MUST BE CHECKED "YES" OR "NO." This health statement must be complete or the application will be returned. Inaccurate health information may result in the policy being cancelled retroactively. It is your responsibility to notify the carrier of any change in health status while application is pending.							
Respond to the following questions:		YES	NO	Within the past 5 YEARS has any applicant been diagnosed with, treated for, or had any of the following (cont.):		YES	NO
1	Pregnancy/Adoption: Are you, your spouse, or any dependent family member pregnant or financially responsible for an unborn child, or do you anticipate adopting a child in the next 12 months?			21	Female Reproductive Conditions/Disorders: Irregular bleeding, abnormal Pap smear/test, endometriosis, recurring pelvic pain, or pelvic inflammatory disease or any other disorder of the reproductive system?		
2	Pregnancy/Fertility Related Treatment: Are you, your spouse, or any dependent family member being treated for infertility, fertility evaluation or treatment (including medication), miscarriage, complications related to pregnancy (including premature births)?			22	Digestive Conditions/Disorders: Ulcers, hernias, chronic diarrhea, diverticulitis, diverticulosis, irritable bowel syndrome, reflux, GERD, any other gallbladder or digestive disorder, hemorrhoids, polyps, or any other rectal disorder?		
3	Last Menstrual Period: Have you, your spouse or any eligible child (whether or not proposed for insurance) missed her last menstrual period? If yes, provide date of last menstrual cycle on the following page.			23	Nervous, Mental and Behavioral: Mental health counseling, psychotherapy, depression, stress, anxiety, attention deficit hyperactivity disorder (ADHD), mental health disorder, or chemical imbalance that required consultation or medication?		
Within the past 12 MONTHS has any applicant:		YES	NO	Within the past 10 YEARS has any applicant been diagnosed with or treated for any of the following:		YES	NO
4	Prescriptions/Medications/Immunizations: Been prescribed or taken any prescription or over-the-counter medications, drugs, or shots (including immunizations, birth control, etc.)?			24	Gout, arthritis, Rheumatoid arthritis, fibromyalgia, or scleroderma?		
5	Conditions Requiring Follow Up Medical Consult/Treatment: Do you, your spouse or any dependent family member have a condition for which hospitalization, tests, consultation, evaluation, surgery, or medication have been advised, but not completed?			25	Musculoskeletal Conditions/Disorders: Ankylosing spondylitis, neuropathy, osteogenesis imperfecta, osteoporosis, herniated and/or ruptured disc, spina bifida, kyphosis, scoliosis, spinal stenosis, spondylolisthesis, or spondylosis or other musculoskeletal disorder?		
6	Medical Consult/Treatment: Consulted or received treatment from a doctor, chiropractor, counselor, therapist, or other health care provider, including routine & wellness care?			26	Digestive Conditions/Disorders: Crohn's disease, Colitis, colostomy, or ileostomy or other digestive disorder?		
7	Conditions Requiring Initial Medical Consult/Treatment: Had a health condition, problem, disorder, or any other medical or mental health conditions not listed for which medical or mental health advice or treatment has <u>not</u> been sought ?			27	Alcohol or Drug Use/Abuse: been advised to reduce/limit alcohol use, or attended Alcoholics Anonymous (or similar program) for his/her own alcohol consumption, drug dependency, abuse, or misuse of prescribed or non-prescribed drugs such as opiates, stimulants, depressants, and/or hallucinogens?		
Within the past 5 YEARS has any applicant been diagnosed with, treated for, or had any of the following:		YES	NO	28	Eating Disorders/Obesity Treatment: including bulimia, anorexia, or obesity and any surgical services for obesity.		
8	Urinary, bladder, incontinence, kidney or liver conditions or disorders? Kidney stones, jaundice, nephritis, or any other disorder of the liver, kidneys, or pancreas?			29	Respiratory Conditions/Disorders: RSV, reactive airway disease, tuberculosis, asthma, sleep apnea, pleurisy, COPD, sarcoidosis, emphysema?		
9	Neurological Disorders: Recurring headaches, migraines, head injury, epilepsy, seizures, or convulsions or other neurological disorder?			30	Tobacco use (chewing or smoking)? Quit Date: _____		
10	Metabolic and Endocrine Conditions/Disorders: Lupus, thyroid disorder, goiter, or any other lymph system disorder?			Has any applicant EVER been diagnosed with or treated for any of the following:		YES	NO
11	Eyes, ears, nose, sinus, or throat conditions/disorders or any other respiratory system disorder including allergies or hay fever?			31	Transplant or Implanted Device: Any organ or tissue transplant, pacemaker or other implanted device?		
12	Skin Conditions/Disorders: Acne, psoriasis, eczema, growths (except warts), abnormal moles, abnormal birthmarks, or any other skin disorder?			32	Nervous, Mental and Behavioral: Bipolar affective disorder, manic depression, schizophrenia, chronic organic brain syndrome, or psychotic disorder?		
13	Breast Conditions/Disorders: Breast lumps, breast augmentation, or breast reduction?			33	Birth Defects/Congenital Abnormalities: premature birth, development or learning disability, mental impairment, Down syndrome, or autism spectrum disorder?		
14	Heart Conditions/Disorders: Chest pain, high blood pressure, high cholesterol, irregular heart beat, or any other heart condition?			34	Heart and Circulatory Conditions/Disorders: Heart murmur, heart attack, bypass surgery, angioplasty/stent, blood clot, stroke, heart surgery, or coronary artery disease, or congestive heart failure?		
15	Back, neck, bone, joint or spinal disorder: bone or joint disorders (including foot, knee, jaw, fracture, dislocation or joint replacement)?			35	Brain/Nervous System Conditions/Disorders: Multiple sclerosis, muscular dystrophy, cerebral palsy, Lou Gehrig's disease (ALS), Parkinson's disease, Alzheimer's disease, or dementia?		
16	Blood Conditions/Disorders: Hemophilia, anemia, blood or bleeding disorder?			36	Diabetes (type I or II), insulin resistance?		
17	Male Reproductive Conditions/Disorders: Impotence, prostate or testicular disorder, or abnormal PSA or other reproductive disorder?			37	Immune System Conditions/Disorders: Immune system diseases, human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), or AIDS related complex (ARC)?		
18	Circulatory System Conditions/Disorders: Varicose veins, or any other circulatory disorder?			38	Cancer/Tumors: (including skin cancer or melanoma) or tumors?		
19	Hospitalization/Surgery: Have you, your spouse or any dependent family member been hospitalized or had surgery?			39	Urinary/Liver Conditions/Disorders: Cirrhosis, hepatitis, or renal failure?		
20	Sexually transmitted diseases?			OTHER MEDICAL INFORMATION		YES	NO
				40	Any medical condition or treatment that you are unsure of where it fits in above?		

J. ACKNOWLEDGMENT AND SIGNATURE

I agree to abide by the Plan's enrollment provisions. I understand that coverage cannot start until after I have served the waiting period agreed to by the employer as recorded on the Plan's records. I authorize my employer to act as my agent in all matters of administration of the group program, and acknowledge that my employer is in no way acting as agent for the Plan.

I understand there may not be participating providers in all specialty fields.

I acknowledge that I have had the opportunity to enroll, but do not wish to make application for those individual(s) listed in the WAIVING MEMBERS section above (or any eligible family member not listed). In waiving coverage, I am aware that waiving members (including myself, if I am waiving) may not enroll until my group's anniversary, unless the waiving member qualifies for a Special Enrollment Period (SEP). If I have waived enrollment for myself or any of my dependents (including my spouse) because of other health insurance or group health plan coverage, I may in the future be qualified for a SEP and be able to enroll the waived individuals in this plan, provided I request enrollment within 30 days after the other coverage of the individual(s) ends due to loss of eligibility or an employer's ceasing to contribute toward that other coverage. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I understand that credit for prior coverage will be based upon the information contained in this application. If any information provided is false or incomplete, the Plan and/or its subsidiaries may without advance notice declare the contract null and void and cancel the coverage retroactive to its original effective date or impose the pre-existing condition waiting period and deny claims that are pre-existing.

I further certify that all information completed on this form is true, correct and complete and acknowledge my coverage is subject to cancellation or other action permissible at law, if any completed information is found to be false or incorrect.

Any matter in dispute between myself and the Plan may be subject to arbitration as an alternative to court action pursuant to the rules of the American Arbitration Association or other recognized arbitrator, a copy of which is available on request from the Plan. The Plan shall bear the costs of arbitration, filing fees, administrative fees and arbitrator fees. Other expenses of arbitration, including, but not limited to: attorney fees, expenses of discovery, witnesses, stenographer, translators, and similar expenses, will be borne by the party incurring those expenses. Any decision reached by arbitration shall be binding upon both myself and the Plan. The arbitration award may include attorney's fees, if allowed by state law, and may be entered as a judgment in any court of proper jurisdiction.

I attest that all information on this form is accurate. I have read the Acknowledgment of this document and agree to its terms. I have also completed the Authorization to Disclose Protected Health Information form that accompanies this application.

Subscriber Signature _____ Date _____



Utah Group Business (2 - 50 Eligible Employees) Employee Enrollment Form

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Corporate address – Do not send applications here.

Member Aetna ID Number (if available)

Employer Name _____ **INSTRUCTIONS:** You, the employee, must complete this enrollment form in full or it will be returned to you resulting in a delay in processing. You are solely responsible for its accuracy and completeness.

A. Coverage Selection - Please print clearly, using black ink. (Shaded sections for Employer/Aetna Use Only)

Control/Group No.	Suffix	Account	Plan No.	Class Code	Control/Group No.	Suffix	Account	Plan No.	Control/Group No.	Suffix	Account	Plan No.
1. Medical - Check one. <input type="checkbox"/> UT PPO 250 80/60 <input type="checkbox"/> UT PPO 3000 80/60 <input type="checkbox"/> UT PPO 500 80/60 <input type="checkbox"/> UT PPO 10,000 100% <input type="checkbox"/> UT PPO 750 80/60 <input type="checkbox"/> UT 2500 Coinsurance <input type="checkbox"/> UT PPO 750 Value <input type="checkbox"/> UT 2500 100% HSA Compatible <input type="checkbox"/> UT PPO 1000 80/60 <input type="checkbox"/> UT 2500 80% HSA Compatible <input type="checkbox"/> UT PPO 1000 Value <input type="checkbox"/> UT 3500 80% HSA Compatible <input type="checkbox"/> UT PPO 1500 80/60 <input type="checkbox"/> UT Basic 1200 HSA Compatible <input type="checkbox"/> UT PPO 1500 Value <input type="checkbox"/> UT Basic 1500 <input type="checkbox"/> UT PPO 2000 80/60 <input type="checkbox"/> UT Limited Benefit 50/50 <input type="checkbox"/> UT Indemnity					2. Dental - Check one. Standard Plans: <input type="checkbox"/> Option 1: PPO Max 1000 <input type="checkbox"/> Option 2: PPO Active 1000 <input type="checkbox"/> Option 3: PPO 1000 <input type="checkbox"/> Option 4: PPO Max 1500 <input type="checkbox"/> Option 5: PPO Active 1500 <input type="checkbox"/> Option 6: PPO 1500 <input type="checkbox"/> Out-of-State Indemnity: <input type="checkbox"/> 1000 <input type="checkbox"/> 1500 Voluntary Plans: <input type="checkbox"/> Option V1: PPO 1000 <input type="checkbox"/> Option V2: PPO 1500 <input type="checkbox"/> Out-of-State Indemnity: 1000 Before today, were you covered under this employer's dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No					3. Life and Disability <input type="checkbox"/> Basic Life/AD&D Ultra™ <input type="checkbox"/> Optional Dependent Life <input type="checkbox"/> Life & Disability Packaged Plan <input type="checkbox"/> Short Term Disability Beneficiary Designation - Full Name (First, Middle, Last) Beneficiary Social Security Number Relationship to Employee		

B. Employee Information - Must be completed by the employee.

Last Name, First Name, M.I.			Primary Language Spoken (Optional)		
Work Address		City, State	ZIP Code	Work Telephone	
Salary (optional) \$	<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	Check One:	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	No. of Dependents Excluding Self	

C. Health Questionnaire for Groups Enrolling 2 – 50 Employees (and employees of groups enrolling employees who are requesting Basic Life benefits greater than the Guaranteed Issue Level) -- Please complete the Utah Small Employer Health Insurance Application.

D. Individuals Covered - List individuals for whom you are enrolling or adding/changing/removing coverage. Insert additional sheets if necessary.

(A)dd (C)hange (R)emove	Name (Last, First, M.I.)	Incapacitated	Coverage Election	Dental Office ID Number (if applicable)	Current Patient
Employee 1.		Yes <input type="checkbox"/>	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life/Dis		Yes <input type="checkbox"/>
Spouse 2.		<input type="checkbox"/>	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life		<input type="checkbox"/>
Child 3.		<input type="checkbox"/>	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life		<input type="checkbox"/>
Child 4.		<input type="checkbox"/>	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life		<input type="checkbox"/>
Child 5.		<input type="checkbox"/>	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life		<input type="checkbox"/>
Child 6.		<input type="checkbox"/>	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life		<input type="checkbox"/>

E. Dependent Information

List any dependent in Section C living at another address. Name: _____

Why? What is their address? _____

If any dependent's last name differs from yours, explain. Name: _____

Reason: _____

F. Race/Ethnicity - Optional (This information is designed for the purpose of data collection and will not be used for determining eligibility, rating or claim payment.)

Employee <input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02	Child <input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02
1. <input type="checkbox"/> Hispanic or Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____	4. <input type="checkbox"/> Hispanic or Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____
Spouse <input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02	Child <input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02
2. <input type="checkbox"/> Hispanic or Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____	5. <input type="checkbox"/> Hispanic or Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____
Child <input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02	Child <input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02
3. <input type="checkbox"/> Hispanic or Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____	6. <input type="checkbox"/> Hispanic or Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____

Conditions of Enrollment

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

- I acknowledge that by enrolling in the following plans, coverage is provided by the following entities (collectively referred to as "Aetna"):
 - Aetna PPO plans: Aetna Life Insurance Company
 - Life, Accidental Death & Dismemberment, disability, dental and all other coverages: Aetna Life Insurance Company
- I understand and agree that my employer's enrollment form will determine coverage and that there is no coverage unless and until both the eligible employee enrollment form and employer applications have been accepted and approved by Aetna. Even if this enrollment form is approved, any misstatements or omissions may result in future claims being denied and the policy or my coverage under the policy being rescinded or reevaluated, as of the effective date, for eligibility and rating purposes.

For life and disability coverages: 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 benefit 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.
- I understand and agree that this Enrollment/Change Request may be transmitted to Aetna or its agent by my employer or its agent. I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("Providers"), including pharmacies or pharmacy database benefit managers to give Aetna or its agent information concerning the medical history, prescription utilization history, services or treatment provided to anyone listed on this Enrollment/Change Request form, including those involving mental health and substance abuse. I further authorize 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 have discussed the terms of this authorization with my spouse and competent adult dependents and I have obtained their consent to those terms. This authorization will remain valid for the term of the coverage and so long thereafter as allowed by law. I understand that I am entitled, as is any authorized representative that I may designate, to receive a copy of this authorization upon request and that a photocopy is as valid as the original.
- Authorizations signed for the purpose of collecting information in connection with this enrollment form for an insurance policy, a policy reinstatement or a request for a change in policy benefits shall remain valid for thirty (30) months from the date signed. Authorizations signed for the purpose of collecting information in connection with a claim for benefits shall remain valid for the term of this coverage or for so long as allowed by law. The information, as well as other personal or privileged information, subsequently collected by the insurance institution or agent may, in certain circumstances, be disclosed to third parties without authorization. A right of access and correction exists with respect to all personal information collected. Further disclosures required by **Utah** law will be furnished to the policyholder upon request. Personal information may be collected from persons other than the individual or individuals proposed for coverage.
- 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.
- I understand and agree that providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.
- I understand and agree that, with certain exceptions described in the plan documents, HMO and DMO plans only provide coverage for referred benefits, and that, in order to be covered, services must be performed either by a participating primary care physician, primary care dentist, or by the participating specialist, hospital, pharmacy, dentist, or other provider as authorized by a referral from a participating primary care physician.
- I understand and agree that, as described in the plan documents, when enrolled for medical and disability coverage in other than an HMO plan, any pre-existing conditions for my spouse, dependents or myself may not be covered for 12 months.

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.

I represent that all information supplied in this form is true and complete. I have read and agree to the Conditions of Enrollment on this **Utah** Group Business (2 - 50 Eligible Employees) Employee Enrollment/Change Form. I understand that, in the event I fail to sign this form within 31 days after the above transaction request or for any reason Aetna does not receive notice of the above transaction request within a reasonable time following the event, my and my dependents' eligibility may be affected. I am employed by the employer shown on Page 1 at the regular place of business.

Employee Signature X	Date (Month/Day/Year)
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