NOTE: Before submitting this completed form to your employer, you may wish to protect the confidentiality of your health information by taping or stapling the form so that pages 3, 4, 5 and 6 are not visible.

Ohio Business (2 - 100 Eligible Employees)
Employee Enrollment/Change Form

Group Number
Member Aetna ID Number (if available)

Company 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. **If waiving coverage, please complete Sections B and G.**

Effective Date / **Date of Hire**	☐ New Hire ☐ Rehire/Reinstatement ☐ New Group Enrollment ☐ Late Enrollment ☐ Other _____	☐ Change of Coverage ☐ Add Spouse/ Dependent Child ☐ Name Change ☐ Other _____	☐ Employee Termination ☐ Remove Spouse/ Dependent Child ☐ Cancel Coverage	COBRA/State Continuation for: ☐ Employee ☐ Dependent Length of Continuation: ☐ 18 ☐ 36 ☐ Other _____ Original Qualifying Event Date _____ Qualifying Event _____

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 applicable boxes.
☐ Employee ☐ Spouse ☐ Child(ren)
☐ Health Network Option℠ –
Plan Option _____
☐ Savings Plus –
Plan Option _____
☐ Choice® POS (Open Access) –
Plan Option _____
☐ Managed Choice® POS (Open Access) –
Plan Option _____
☐ Open Choice® PPO –
Plan Option _____
☐ Indemnity
☐ Other – _____

2. Dental - Check applicable boxes.
☐ Employee ☐ Spouse ☐ Child(ren)
To enroll, enter plan number and name elected below.
Standard Plans:
Plan Number: _____
Plan Name: _____
FOC *Options:* DMO® ☐ *or* PPO ☐
Voluntary Plans:
Plan Number: _____
Plan Name: _____
FOC *Options:* DMO® ☐ *or* PPO ☐

Before today, were you covered under this employer's dental plan? ☐ Yes ☐ No

3. Life and Disability - Check applicable boxes.
☐ Employee ☐ Spouse ☐ Child(ren)
Check if applicable:
☐ Basic Life/AD&D Ultra®
☐ Optional Dependent Life
☐ Short Term Disability
☐ Life & Disability Packaged Plan

Beneficiary Designation - **Full Name** (First, Middle, Last)

Beneficiary Social Security Number

Relationship to Employee

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

Social Security Number	Last Name, First Name, M.I.		Job Title	Home Telephone	Primary Language Spoken (Optional)
Home Address		Apt. No.	City, State		ZIP Code
Work Address			City, State	ZIP Code	Work Telephone

Salary $	☐ Hourly ☐ Weekly ☐ Monthly	No. of Hours Worked Per Week	Check One	☐ Full-Time ☐ Part-Time	☐ 1099 ☐ Retired	☐ Seasonal ☐ Temporary	No. of Dependents Including Spouse

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

NOTE FOR MEDICAL COVERAGE: While the Federal Patient Protection and Affordable Care Act mandates coverage of dependent children up to age 26 and the State of Ohio mandates coverage of dependent children meeting certain criteria up to age 28, your plan may allow coverage beyond these ages. Some exceptions may apply. Please refer to your plan documents or contact your benefits administrator.

1. Employee Name (Last, First, M.I.)			Sex (M/F)	Social Security Number
Birthdate (MM/DD/YYYY)	Status ☐ Single ☐ Divorced ☐ Married ☐ Widowed ☐ Legally Separated	Coverage Election ☐ Medical ☐ Dental ☐ Life/Disability		PCP Provider ID Number
2. ☐ **Spouse** ☐ **Other** (Last, First, M.I.)			Sex (M/F)	Social Security Number
Birthdate (MM/DD/YYYY)	Status ☐ Different Last Name*	Coverage Election ☐ Medical ☐ Dental ☐ Life		PCP Provider ID Number
3. ☐ **Child** ☐ **Stepchild** ☐ **Other** (Last, First, M.I.)			Sex (M/F)	Social Security Number
Birthdate (MM/DD/YYYY)	Status ☐ Different Last Name* ☐ Lives at another address* ☐ Full-Time Student (Life Only) ☐ Disabled	Coverage Election ☐ Medical ☐ Dental ☐ Life		PCP Provider ID Number
4. ☐ **Child** ☐ **Stepchild** ☐ **Other** (Last, First, M.I.)			Sex (M/F)	Social Security Number
Birthdate (MM/DD/YYYY)	Status ☐ Different Last Name* ☐ Lives at another address* ☐ Full-Time Student (Life Only) ☐ Disabled	Coverage Election ☐ Medical ☐ Dental ☐ Life		PCP Provider ID Number

D. Dependent Information

List any dependent in Section C living at another address.	Name:	Reason:	Address:
If any dependent's last name differs from yours, explain.	Name:	Reason:	

FOR DEPENDENT LIFE COVERAGE: If age 19 and over and a full-time student, provide information below.

Child Name	School Name	Expected Graduation Date	Number of Credit Hours

E. Medicare Information

Name of Person	Medicare Part A	Medicare Part B	Medicare Part D	Over Age 65	Disability	End-Stage Renal Disease Effective Date
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

F. Other Insurance

Does anyone age 19 and over enrolling on this enrollment form have current or prior medical coverage? ☐ Yes ☐ No

Proof of coverage should accompany this enrollment form for pre-existing condition credit and if an employee is waiving coverage.
Acceptable forms of proof are:

1. Certificate of Creditable Coverage from prior carrier, or
2. Copy of ID card or most recent payroll stub showing medical coverage deduction, or
3. Copy of most recent medical premium bill from prior carrier.

Failure to provide Proof of Prior Coverage may subject you or a family member age 19 and over to the full pre-existing conditions limitation with no credit for prior coverage. You may request a Certificate of Creditable Coverage from your prior carrier. **NOTE**: If your Plan contains a pre-existing conditions provision, the pre-existing conditions exclusion and limitation will not apply to a person under 19 years of age.

Name of Covered Individual	Carrier Name	Group Number	Start Date	Termination Date	Health
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

G. Declination/Waiver of Coverage - *Check all that apply.*

I understand I am eligible to apply for this coverage through my employer; however, I am waiving coverage as noted below.

☐ Employee: ☐ Medical ☐ Dental ☐ Life ☐ Disability	**Reason for Declining Coverage** *(If applicable, please attach front/back of your health coverage ID card.)*:
☐ Spouse: ☐ Medical ☐ Dental ☐ Life	☐ Spousal group coverage ☐ COBRA coverage
☐ Child(ren): ☐ Medical ☐ Dental ☐ Life	☐ Medicare ☐ TRICARE or CHAMPVA
	☐ Medicaid ☐ Another group plan provided by my employer
	☐ Individual coverage ☐ Do not want
	☐ Retiree coverage
	☐ Other _____

I certify I have been given the right to apply for this coverage; however, I am waiving coverage as noted above. By declining this group coverage I acknowledge that myself and/or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage. Pre-existing conditions, when enrolled in this plan, may not be covered for twelve months. **NOTE:** If your Plan contains a pre-existing conditions provision, the pre-existing conditions exclusion and limitation will not apply to a person under 19 years of age.

Please sign here ONLY if you are declining coverage for yourself and/or dependent(s).	***Date (Month/Day/Year)***
X Employee Signature	

H. 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	**Child/Stepchild/Other**
1. ☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____	**3.** ☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____
Spouse/Other	**Child/Stepchild/Other**
2. ☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____	**4.** ☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____

I. Health Questionnaire for Groups Enrolling 2 - 9 Eligible Employees (or 2 - 50 if enrolling for life above the Guarantee Issue amount) and All New Enrollees for Existing Groups with 2-50 Eligible Employees. All new business groups do not need to complete this section if they are eligible to complete the Group Medical Questionnaire.

Health History for Individuals and Their Dependents. ***The following information is confidential and will not be seen by or given to your employer.***

- ALL of the questions must be answered by you or your application will be returned.
- Incomplete applications may delay the effective date of your coverage.

In the past **five (5)** years, has any person enrolling for this coverage consulted with or been examined or treated by any health care professional for any illness, injury, or health condition listed below? Check all that apply.

1. Circulatory ☐ Yes ☐ No	☐ Ablation ☐ Anemia ☐ Aneurysm ☐ Angina ☐ Angioplasty ☐ Blood Clot ☐ TIA ☐ Arrhythmia ☐ Blood Disorder	☐ Blood Vessels ☐ Bypass ☐ CAD ☐ Chest pain ☐ Heart Attack ☐ Heart Disease ☐ Heart Murmur ☐ Hemophilia ☐ ICD Implant	☐ Palpitations ☐ Phlebitis ☐ Skin Ulcer ☐ Stroke ☐ Stent ☐ High Blood Pressure ☐ High Cholesterol ☐ High Triglycerides ☐ Sickle Cell Anemia	☐ Varicose Veins ☐ Tachycardia ☐ Heart Valve Disorder ☐ Pacemaker - Reason inserted _____ ☐ Peripheral Vascular Disease ☐ Congestive Heart Failure ☐ Irregular Heart Beat ☐ Other _____
2. Intestinal ☐ Yes ☐ No	☐ Cirrhosis ☐ Colitis ☐ Crohn's ☐ GERD ☐ Diverticulitis	☐ Gallbladder ☐ Hernia ☐ Polyp ☐ Reflux ☐ Pancreatitis	☐ Tumor ☐ Ulcer ☐ Ulcerative Colitis ☐ Gastric Bypass/Stapling ☐ Colon Disorder	☐ Colostomy: ☐ Total or ☐ Partial ☐ Ileostomy: ☐ Total or ☐ Partial ☐ Other _____
3. Kidney/Urinary/ Bladder ☐ Yes ☐ No	☐ Bladder Disorder ☐ Kidney Disorder ☐ Polycystic Kidney ☐ Prostate Disorder	☐ Kidney Stone(s) Present ☐ Yes ☐ No How many passed _____ Date last stone passed or surgically removed _____ ☐ Dialysis - Date started _____		☐ Renal Failure ☐ Polyp ☐ End Stage Renal Disease ☐ Other _____

I. Health Questionnaire for Groups Enrolling 2 - 9 Eligible Employees *(continued)*

4. Respiratory ☐ Yes ☐ No

☐ Asthma
☐ Mild ☐ Moderate ☐ Severe
Date of last ER visit _____
☐ Injections - How often _____
☐ Allergies
☐ Injections - How often _____
☐ COPD/Emphysema - On Oxygen ☐ Yes ☐ No
☐ Sleep Apnea: ☐ CPAP or ☐ BiPap
☐ Chronic Bronchitis
☐ Cystic Fibrosis
☐ Lung Disorder
☐ Pneumonia
☐ Polyp
☐ Sarcoidosis
☐ Tuberculosis
☐ Valley Fever
☐ Tumor
☐ Growth
☐ Cyst
☐ Other _____

5. Brain ☐ Yes ☐ No

☐ Acoustic Neuroma
☐ Alzheimer
☐ Concussion
☐ Paralysis
☐ Parkinson's Disease
☐ ALS/Lou Gehrig's Disease
☐ Brain/Head Injury Complications ☐ Yes ☐ No
☐ Migraines
Date of last ER visit _____
☐ Cyst
☐ Hemiplegia
☐ Quadraplegia
☐ Multiple Sclerosis
☐ Tumor
☐ Growth
☐ Seizures/Epilepsy
Date of last seizure _____
Date diagnosed _____
☐ Other _____

6. Cancer ☐ Yes ☐ No

☐ Basal cell
☐ Bladder
☐ Blood
☐ Bone
☐ Breast
☐ Brain
☐ Cervical
☐ Colon
☐ Eye
☐ Liver
☐ Lung
☐ Ovarian
☐ Prostate
☐ Stomach
☐ Thyroid
☐ Testicular
☐ Lymph System
☐ Esophageal
☐ Leukemia
☐ Lymphoma
☐ Hodgkin's Disease
☐ Melanoma
☐ Metastasized
☐ Squamous cell
☐ Other _____
☐ Surgery
☐ Chemo
☐ IV Chemo
☐ Radiation
☐ Stage _____

7. Mental Health ☐ Yes ☐ No

☐ Alcohol Abuse
☐ Anorexia
☐ Anxiety
☐ ADD/ADHD
☐ Autism
☐ Counseling
☐ Drug Abuse
☐ Cocaine use
☐ Marijuana use
☐ Opiate use
☐ Heroin use
☐ Methadone use
☐ Morphine use
☐ Bipolar
☐ Bulimia
☐ Depression
☐ Manic Depression
☐ Schizophrenia
☐ Suicide Attempt
☐ Conduct Disorder
☐ Prescription Drug Abuse
☐ Inpatient Hospitalization
☐ Other _____

8. Reproductive ☐ Yes ☐ No

☐ Abnormal Pap
☐ Breast Disorder
☐ Cyst
☐ Endometriosis
☐ Fibroids
☐ Growth
☐ Infertility
☐ HPV
☐ Menstrual Disorder
☐ Ovarian Cysts
☐ Polycystic Ovarian Syndrome
☐ Pregnant - Due date _____
☐ C section planned ☐ Yes ☐ No
☐ Multiples Expected (# _____)
☐ Complications: ☐ Present ☐ Past
☐ STD
☐ Tumor
☐ Polyp
☐ Other _____

9. Transplant ☐ Yes ☐ No

☐ Bone
☐ Bone Marrow
☐ Cornea
☐ Heart
☐ Heart Valve
☐ Intestine
☐ Liver
☐ Lung (single)
☐ Lung (double)
☐ Pancreas
☐ Skin
☐ Stem Cell
☐ Pending
☐ On Waiting List
☐ Recommended
☐ Other _____

10. Bones/ Muscles/Joint ☐ Yes ☐ No

☐ Back/Neck Disorder
☐ Breast Implants
☐ Chiro adjustments
☐ Physical Therapy
☐ Chronic Fatigue
☐ Carpal Tunnel
☐ Arthritis
☐ Rheumatoid Arthritis
☐ Osteoarthritis
☐ Congenital Disorder
☐ Fibromyalgia
☐ Gout
☐ Pins, screws, plates
☐ Permanent
☐ Temporary
☐ Knee Disorder
☐ Shoulder
☐ Muscular Dystrophy
☐ Amputation
Body part _____
☐ Fracture
Location _____
☐ Joint Replacement
Location _____
☐ Spina Bifida
☐ Sprain/Strain
Location _____
☐ Prosthetic Device
Body part _____
☐ Other _____

11. Endocrine/ Metabolic ☐ Yes ☐ No

☐ Diabetes
Date diagnosed _____
☐ Diet ☐ Insulin
☐ Oral medication
☐ Other _____
☐ Adrenal Gland
☐ Gaucher's Disease
☐ Goiter
☐ Growth Disorder
☐ Graves Disease
☐ Hashimoto Disease
☐ Hepatitis
☐ A ☐ B ☐ C
☐ Other _____
☐ Hypothyroid
☐ Hyperthyroid
☐ Liver Disorder
☐ Pituitary
☐ Thyroid Disorder
☐ Tumor
☐ Growth
☐ Cyst
☐ Other _____

12. Immune ☐ Yes ☐ No

☐ AIDS
☐ HIV
☐ Herpes
☐ HIV or Hepatitis Exposure
☐ Immune Deficiency
☐ Lupus: ☐ Discoid or ☐ SLE
☐ Scleroderma
☐ Other _____

13. Birth Defects/ Congenital Abnormalities ☐ Yes ☐ No

☐ Birthmarks
☐ Cerebral Palsy
☐ Cleft Palate/Lip
☐ Club Foot
☐ Webbed Fingers/Toes
☐ Developmental Delay
☐ Mental Retardation
☐ Down's Syndrome
☐ Heart/Lung Malformation
☐ Premature birth still receiving treatment
☐ Skull/Facial or other physical deformities
☐ Other _____

I. Health Questionnaire for Groups Enrolling 2 - 9 Eligible Employees *(continued)*

14. Eyes/Ears/ Nose/Skin ☐ Yes ☐ No	☐ Acne ☐ Chronic Ear Infections ☐ Glaucoma ☐ Burns: ☐ 1st ☐ 2nd ☐ 3rd degree ☐ Cataracts ☐ Chronic Sinusitis ☐ Psoriasis ☐ Other _____ ☐ Eczema ☐ Deviated Septum ☐ Retinal Disorder
15. Medication(s) ☐ Yes ☐ No	☐ Currently taking prescription medications ☐ Stopped taking prescription medications within the past year ☐ Taking Over-the-Counter medications. If so, show as OTC in the dosage column.
16. Other ☐ Yes ☐ No	☐ Abnormal tests or physical results, except those related to HIV or AIDS (Acquired Immune Deficiency Syndrome) ☐ Condition or disorder not listed above ☐ Hospitalized ☐ Surgery ☐ Injections – what for _____ ☐ Tests results pending ☐ Claims in excess of $5,000 in the past 24 months ☐ Chiropractic adjustments for maintenance ☐ Physical deformity or defect ☐ Non ambulatory, wheel chair bound ☐ Use of assistive crutches/walker ☐ Workers' Comp injury or illness ☐ Tests, treatment or surgery discussed or advised not yet done, except those related to HIV or AIDS (Acquired Immune Deficiency Syndrome) ☐ Tumor - location _____ ☐ Growth - location _____ ☐ Cyst - location _____ ☐ Polyp - location _____ ☐ Other _____
17. Tobacco ☐ Yes ☐ No	☐ Employee: ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Chewing Tobacco ☐ Spouse: ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Chewing Tobacco

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS IN SECTION I, YOU MUST COMPLETE SECTION K.

J. Health Questionnaire for Groups Enrolling 10 - 100 Eligible Employees (and employees of groups enrolling for Life coverage greater than the Guarantee Issue Level)

Health History for Employees and your Dependents. ***The following information is confidential and will not be seen by or given to your employer.***

- ALL of the questions must be answered by you or your dependents or the enrollment form will be returned.
- Incomplete enrollment forms may delay the effective date of your coverage.

Answer all questions.

1. Within the past **five (5)** years has anyone applying for coverage consulted, received treatment, by a doctor, psychiatrist, psychologist, or other practitioner or been diagnosed with any of the following conditions or disorders? (Check all that apply.) ☐ Yes ☐ No

a. ☐ AIDS or HIV
b. ☐ Diabetes
c. ☐ Infertility
d. ☐ Endocrine/ Metabolic
e. ☐ Pancreas
f. ☐ Liver/Hepatitis
g. ☐ Immune System
h. ☐ Blood Disorder
i. ☐ Epilepsy/Seizure
j. ☐ Heart
k. ☐ Paralysis/Paresis
l. ☐ Tumor/Cyst/Growth
m. ☐ Systemic or Discoid Lupus
n. ☐ Lung or Respiratory
o. ☐ Alcohol or Drug Use
p. ☐ Kidney/Bladder/Urinary
q. ☐ Circulatory/Vascular
r. ☐ Digestive/Stomach/Intestinal
s. ☐ Central Nervous System
t. ☐ Pituitary/Adrenal/Growth Disorder
u. ☐ Birth Defects/Congenital Abnormalities
v. ☐ Arthritis/Bone/Joint/Muscle/Prosthetic Device
w. ☐ Mental/Nervous/Emotional/Eating Disorder
x. ☐ Stroke/Brain/Neurological
y. ☐ Transplant: ☐ Recommended ☐ Pending ☐ Complete
z. ☐ Advised to have surgery or course of treatment not yet determined
aa. ☐ Cancer: Type:_____ Stage _____ ☐ Surgery ☐ Chemo ☐ Radiation
bb. ☐ Using: ☐ Crutches ☐ Walker ☐ Wheelchair
cc. ☐ Other _____

2. Is any female currently pregnant? If so, provide due date _____ Check applicable boxes: ☐ C section planned ☐ Multiple Births Expected (# _____) ☐ Complications: ☐ Past or ☐ Present ☐ Yes ☐ No
3. Has anyone applying for coverage incurred medical expenses in excess of $5,000 in the past 24 months? ☐ Yes ☐ No
4. Has anyone applying for coverage been prescribed medications in the past 12 months? ☐ Yes ☐ No
5. Does anyone applying for coverage have a known condition that requires on-going treatment? ☐ Yes ☐ No
6. Do you or your spouse use tobacco products? ☐ Employee ☐ Spouse ☐ Yes ☐ No

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS IN SECTION J, YOU MUST COMPLETE SECTION K ON THE FOLLOWING PAGE.

K. Health Questionnaire – Details for "Yes" Responses in Sections I and J.

List all individuals enrolling for coverage. Name	Sex	Age	Height	Weight	Smoker	Currently Taking Prescription Medication(s)
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No

Provide details below to any boxes checked above. ***(If additional space is needed, attach a separate sheet and be sure to sign and date the sheet.)***

Ques. No.	Name of Individual	Condition/Diagnosis/ Treatment	Date of Onset	Date Treatment Ended	Names of Prescription Medication	Dosage	Still Taking Medication
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

Conditions of Enrollment

On behalf of myself and the dependents listed on the reverse side:

1. I acknowledge that by enrolling in the following plans, coverage is provided by the following entities (collectively referred to as "Aetna"):
   - Aetna Choice® POS (Open Access), Aetna Open Access HMO and Aetna Health Network Option℠: Aetna Health Insurance Company and/or Aetna Health Inc.
   - Aetna Savings Plus: Aetna Life Insurance Company and Aetna Health Insurance Company
   - Aetna Open Choice® PPO: Aetna Life Insurance Company
   - Life, Accidental Death & Dismemberment, disability, dental and all other coverages: Aetna Life Insurance Company.
2. I understand and agree that my employer's application will determine coverage and that there is no coverage unless and until both this Enrollment/Change Form and the employer application have been accepted by Aetna. Even if this Enrollment/Change Form is accepted, any intentional and material misstatements or omissions that amount to fraud may result in future claims being denied and my coverage under the policy being rescinded or reevaluated, as of the effective date, for eligibility and rating purposed except as otherwise provided by law.
   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. For Dependent Life, dependents are eligible from 14 days of age up to their 19th birthday or up to their 23rd birthday, if a full-time student.

continued on the following page

Conditions of Enrollment *(continued)*

3. I understand and agree that this Enrollment/Change Form 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 to Aetna or its agent information concerning the medical history, services or treatment provided to anyone listed on this enrollment form, including those involving mental health, substance abuse and HIV/AIDS. 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. Authorizations signed for the purpose of collecting information in connection with this application 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 it is 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. I understand that I am 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.
5. I understand and agree that, with the exception of Aetna Rx Home Delivery®, all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.
6. 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.
7. I understand and agree that, as described in the plan documents, when enrolled for medical coverage other than an HMO plan, and pre-existing conditions for my spouse, dependents or myself may not be covered for 12 months. **NOTE:** If your Plan contains a pre-existing conditions provision, the pre-existing conditions exclusion and limitation will not apply to a person under 19 years of age.

Misrepresentation

8. Any person who knowingly and with intent to defraud any insurance company or other person files 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 commits a fraudulent insurance act.

I represent that all information supplied in this form is true and complete. I have read and agree to the Conditions of Enrollment and Misrepresentation on this **Ohio** Employee Enrollment/Change Form. I understand that, in the event I fail to sign this form within 31 days of my eligibility date 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, and I am working full time at least 25 hours per week for this employer at the regular place of business.

Employee Signature	***Employee E-mail Address (optional)***	***Date (Month/Day/Year)***
X		