Enrollment/Change Request
Aetna Health / Vision

OnePoint HRO, LLC	Control	Suffix	Account	Plan Number

A. Type of Activity - Employee Completes Sections A - E. Please Print Clearly.

Instructions:	Enrollment	Change – *check all that apply*	Remove or Terminate – *Check all that apply*	Waive Medical Coverage	Waive Vision Coverage
Refer to the instructions on the back before completing this form. You must complete this application in full or it will be returned to you resulting in a delay in processing. You are solely responsible for its accuracy and completeness.	New Enrollment Effective Date ______/______/______ Date of Hire ______/______/______	☐ Add Spouse ☐ Add Dependent Child ☐ Name Change ☐ Other ☐ Change Plan ☐ COBRA Election Date of Event ______/______/______ Reason ______________	☐ Remove Spouse ☐ Remove Dependent Child ☐ Employee Withdrawal/Termination Effective Date: ______/______/______ Reason: ________________________	☐ Other group health insurance ☐ Medicare Coverage (claim #__________) ☐ Not interested at this time, no other ins	☐ Other group vision insurance ☐ Not interested at this time, no other ins ☐ Other: ______________

B. Employee Information

Social Security Number	Gender M F ☐ ☐	Date of Birth	First Name Last Name
Home Address	Apt. No	City, State	Zip Code
Home Telephone	Employer Name		

C. Plan Options

- ☐ 1. Value Plan
- ☐ 2. HDHP 5000/80%
- ☐ 3. HDHP 3000/90%
- ☐ 4. HMO 2500/70%
- ☐ 5. HMO 1500/80%
- ☐ 6. MC OA 3000/70%
- ☐ 7. MC OA 2000/80%
- ☐ 8. MC OA 3000/100%
- ☐ 9. MC OA 1000/80%
- ☐ 10. MC OA 500/80%
- ☐ 13. Whole Hlth 1000/70%
- ☐ 14. Whole Hlth 2750/80%
- ☐ Aetna Vision

D. Individuals Covered – List Individuals for whom you are adding/change/removing coverage.

MEDICAL (A)dd (C)hange (R)emove	VISION (A)dd (C)hange (R)emove	First Name Last Name	Date of Birth	Gender M F	Social Security Number (if dependent has no SSN, write "None")	Handicapped
		Employee	*To be completed in Section B*			N/A
		Spouse		☐ ☐		Yes ☐
		Child		☐ ☐		Yes ☐
		Child		☐ ☐		Yes ☐
		Child		☐ ☐		Yes ☐

Does any dependent listed above live at a different address than the employee? If yes, who and what address?

Explain the circumstances:

E. Employee Signature

I certify that all information supplied in this form is true and complete to the best of my knowledge and/or belief. I have read and agree to the Conditions of Enrollment on the reverse side of this Enrollment/Change Request form.	Employee Signature – *Required* X	
	Date / /	Email Address

Instructions

Employer - Complete the Employer Group Information at the top of the form.

Employee - Complete Sections A - E.

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:
- Select only an option(s) offered by your employer.
- Check one Health Plan Option box and the Aetna Vision Box to enroll

Section D - Individuals Covered:
- Add/Change/Remove • Use "A", "C. or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependent(s), if applicable. Indicate
- Gender, Birthdate, and Social Security Number for each individual listed.
- If a dependent is Handicapped and financially dependent, check "Yes" and provide proof of handicapped status from the attending physician.

Section E - Employee Signature:
- Complete this section for all new enrollments or coverage changes.
- Employee must sign and date the Enrollment/Change Request 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. I acknowledge that by enrolling in the following plans, coverage is underwritten or administered by the following entities (collectively referred to as "Aetna"):
   - HMO / Aetna Health Network Only: Aetna Health Inc.
   - QPOS / Aetna Choice POS / Aetna Health Network Option: Aetna Health Inc., Aetna Health Insurance Company and/or Aetna Life Insurance Company.
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 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 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 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. 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 entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original.
4. The plan documents (Schedule of Benefits, Group Agreement. Certificate of Coverage, Group Policy, Group Insurance Certificate) 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 plans only provide coverage for refined benefits, and that, in order to be covered, services 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.

Misrepresentation

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.