AETNA LIFE INSURANCE COMPANY
151 Farmington Avenue
Hartford, CT 06156

AETNA HEALTH INSURANCE COMPANY OF NEW YORK
151 Farmington Avenue
Hartford, CT 06156

New York Small Group Business Employee Enrollment/Change Form for Medical, Dental and Vision Coverage

INSTRUCTIONS: You, the employee, must complete this enrollment form in full. If you do not, we will return it to you, and that can delay its processing. You alone are responsible for its accuracy and completeness. **If you are declining coverage, you must complete section E. Please use only black ink to complete this form.**

Aetna member ID number (if available)

Company name GLOBAL HEALTHY LIVING FOUNDATION #106677652

Effective date / **Date of hire**			
	☑ New hire ☐ Rehire / reinstatement ☐ New group enrollment ☐ Late enrollment ☐ Waiver ☐ Open enrollment ☐ Loss of coverage	☐ Add spouse ☐ Add domestic partner ☐ Add dependent child ☐ Change of coverage ☐ Name change	☐ Employee termination ☐ Remove spouse ☐ Remove domestic partner ☐ Remove dependent child ☐ Cancel coverage ☐ Other _____

☐ **COBRA** ☐ **Continuation for:** ☐ Employee ☐ Dependent Length of continuation: ☐ 18 months ☐ 36 months ☐ Other _____
Qualifying event _____ Original qualifying event date _____ Loss of coverage date _____

A. Employee information – ***You must complete this section.***

Social Security number	Last name, first name, middle initial		Job title
Home address	Apt. number	City, state	ZIP code
Work address		City, state	ZIP code
Home telephone ( ) -	Work telephone ( ) -	Primary language spoken (optional)	Number of dependents (including spouse or domestic partner) enrolling for medical coverage

Marital status	Number of hours worked a week	Check one
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally separated		☐ Full time ☐ Part time ☐ 1099 ☐ Retired ☐ Seasonal ☐ Temporary ☐ Union ☐ COBRA

B. Coverage selection – ***Top boxes for employer and Aetna use only***

Control/Group number	Suffix	Account	Plan number	Class code

1. Medical

- ☐ Signature Open Access Elect Choice® (OAEPO) – Plan option _____
- ☑ Open Access Elect Choice® (OAEPO) – Plan option _____
- ☐ Open Access Elect Choice® (OAEPO) HSA Compatible (Calendar Year) – Plan option _____
- ☐ Open Access Elect Choice® (OAEPO) HSA Compatible PY (Plan Year) – Plan option _____
- ☐ Savings Plus Open Access Elect Choice® (OAEPO) – Plan option _____
- ☐ Savings Plus Open Access Elect Choice® (OAEPO) HSA Compatible – Plan option _____
- ☐ Other – Plan option _____

Aetna Health Insurance Company of New York underwrites Signature EPO plans. Aetna Life Insurance Company underwrites all other Aetna EPO plans.

Control/Group number	Suffix	Account	Plan number

2. Dental

Non-voluntary Plans: Option _____ FOC: ☐ DMO® *or* ☐ PPO

Voluntary Plans: Option _____ FOC: ☐ DMO® *or* ☐ PPO

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

Creditable coverage is allowed for new members enrolling in voluntary takeover groups. New hires please see below if applicable:
New Hire selecting a Voluntary plan **and your Aetna plan is a takeover group:** Were you covered for 12 months under a dental plan within the last 90 days that included both Preventive and basic coverage? Discount dental and preventive-only plans do not apply. ☐ Yes ☐ No

Employees in AZ, CA, GA, MA, MD, MO, NC, NJ and TX must either live or work within the approved DMO® service area to be eligible to enroll in the DMO®.

Aetna Life Insurance Company underwrites Aetna dental plans.

Control/Group number	Suffix	Account	Plan number

3. Vision *Check box if applicable.*

Aetna Vision℠ Preferred ☐ Yes ☐ No

Aetna Life Insurance Company underwrites Aetna vision plans. First American Administrators, Inc. provides certain claims administration services. EyeMed Vision Care, LLC ("EyeMed") provides certain network administration services.

C. Individuals covered - ***List individuals for whom you are enrolling or adding, changing or removing coverage. Add more sheets if needed.*** **NOTE FOR MEDICAL COVERAGE:** While the Affordable Care Act mandates coverage of dependent children up to age 26, your plan may allow coverage beyond age 26. Please refer to your plan documents or contact your benefits administrator.

1	**Employee name** (Last, first, middle initial)	Sex (M/F)	**Birthdate** (MM/DD/**YYYY**) / /

Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision	Dental office ID number *(if applicable)*	Current patient **Yes** ☐

Primary office ID number *(if applicable)*	Physician first and last name	Provider ID number (*if applicable*)	Current patient **Yes** ☐

2	**Spouse/Domestic partner** (Last, first, middle initial)	Sex (M/F)	**Social Security number**	**Birthdate** (MM/DD/**YYYY**) / /

Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision	Dental office ID number *(if applicable)*	Current patient **Yes** ☐

Primary office ID number *(if applicable)*	Physician first and last name	Provider ID number (*if applicable*)	Current patient **Yes** ☐

3	**Child** (Last, first, middle initial)	Sex (M/F)	**Social Security number**	**Birthdate** (MM/DD/**YYYY**) / /

Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision	Out of area **Yes** ☐	Dental office ID number *(if applicable)*	Current patient **Yes** ☐	Incapacitated Yes ☐ No ☐

Primary office ID number *(if applicable)*	Physician first and last name	Provider ID number (*if applicable*)	Current patient **Yes** ☐

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C. Individuals covered *(Continued)*

4	**Child** (Last, first, middle initial)	Sex (M/F)	**Social Security number**	**Birthdate** (MM/DD/**YYYY**) / /	
Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision		Out of area **Yes** ☐	Dental office ID number *(if applicable)*	Current patient **Yes** ☐	Incapacitated Yes ☐ No ☐
Primary office ID number *(if applicable)*	Physician first and last name		Provider ID number (*if applicable*)		Current patient **Yes** ☐

5	**Child** (Last, first, middle initial)	Sex (M/F)	**Social Security number**	**Birthdate** (MM/DD/**YYYY**) / /	
Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision		Out of area **Yes** ☐	Dental office ID number *(if applicable)*	Current patient **Yes** ☐	Incapacitated Yes ☐ No ☐
Primary office ID number *(if applicable)*	Physician first and last name		Provider ID number (*if applicable*)		Current patient **Yes** ☐

6	**Child** (Last, first, middle initial)	Sex (M/F)	**Social Security number**	**Birthdate** (MM/DD/**YYYY**) / /	
Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision		Out of area **Yes** ☐	Dental office ID number *(if applicable)*	Current patient **Yes** ☐	Incapacitated Yes ☐ No ☐
Primary office ID number *(if applicable)*	Physician first and last name		Provider ID number (*if applicable*)		Current patient **Yes** ☐

D. Dependent information

List any dependent in Section **C** living at another address.

Name	Address

E. Declining coverage – *To be completed if coverage is declined or refused by an eligible employee and / or their eligible family members.*

I understand I am eligible to apply for this coverage through my employer. However, I am declining the coverage I checked below:

☐ Employee: ☐ Medical ☐ Dental ☐ Vision

☐ Spouse / domestic partner: ☐ Medical ☐ Dental ☐ Vision

☐ Children: ☐ Medical ☐ Dental ☐ Vision

Reason for declining coverage

- ☐ Spousal / domestic partner group coverage
- ☐ Parental group coverage
- ☐ COBRA coverage
- ☐ Medicare
- ☐ Medicaid
- ☐ Retiree coverage
- ☐ Another group plan provided by my employer
- ☐ Insurance through another job
- ☐ Individual coverage - On Exchange
- ☐ Individual coverage - Off Exchange
- ☐ TRICARE Military coverage
- ☐ VA coverage
- ☐ I have no other coverage
- ☐ I do not want
- ☐ Other _____

I acknowledge I have been given the right to apply for this coverage. However, I am electing not to enroll. By declining this group coverage I acknowledge that I and / or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage.

Please sign here ONLY if you are declining coverage for yourself and / or dependents. ***Date (Month/Day/Year)***

X Employee signature:

Please PRINT employee name:

F. Coordination of benefits

Will you have other health insurance at the same time as this coverage? ☐ Yes ☐ No
If **yes**, will the Aetna coverage you're applying for replace the coverage you have now? ☐ Yes ☐ No

Name of person	Carrier name	Name of person	Carrier name

Conditions of enrollment

I understand that the following legal entities underwrite the plans I apply for:

- Aetna Health Insurance Company of New York underwrites Aetna Signature EPO plans;
- Aetna Life Insurance Company underwrites all other Aetna EPO plans, Aetna dental plans and Aetna vision plans.

1. My employer's application determines coverage. I don't have coverage until Aetna approves my employee enrollment form and the employer application. Even if Aetna approves the employer application, any misstatements or omissions may result in denial of future claims. Aetna may rescind or reevaluate my coverage under the policy, as of the effective date, for eligibility and rating purposes. If Aetna voids or rescinds coverage, I may be entitled to a refund of any paid premiums from the effective date of coverage. Aetna will give at least 30 days advance written notice to any covered person affected by the proposed rescission. If I elect to receive electronic notifications, I will receive this notice in an electronic (email) format.
2. To support the coverages listed on this enrollment form, Aetna may need information about medical history, services or treatment provided to anyone listed on this form, excluding drug and alcohol records and psychotherapy notes. I authorize that the following entities can provide this information to Aetna or its agents:
   - Physicians
   - Other healthcare professionals
   - Hospitals
   - Other healthcare organizations ("providers"), including
     - Pharmacies
     - Pharmacy database benefit managers
3. I authorize Aetna to use and disclose such information to:
   - Affiliates
   - Providers
   - Other insurers
   - Third party administration
   - Vendors
   - Consultants
   - Governmental authorities with jurisdiction when necessary for:
     - Care or treatment
     - Payment for services
     - Operation of my health plan
     - Conduct related activities
4. I discussed the terms of this authorization with my competent adult dependents. They agreed to these terms. This authorization is valid for 24 months from the signature date. This authorization is valid for the term of the coverage for medical information collected in connection with a medical claim. This authorization is voluntary. But if I don't sign this form, my ability to enroll in the plan may be affected. I have the right to revoke this authorization in writing to Aetna at any time. I can't revoke authorization for information already used or disclosed before I revoked my authorization. I am entitled to receive a copy of this authorization upon request. A photocopy is as valid as the original.
   - The Group Agreement / Group Policy determines the rights and responsibilities of members and will govern in the event they conflict with any:
     - Benefits comparison
     - Summary
     - Other description of the plan
   - Participating physicians, hospitals and other health care providers are independent contractors. They are not Aetna agents or employees. We cannot guarantee the availability of any particular provider. Any provider network is subject to change. We will provide a notice of the change in accordance with applicable state law.

Continued on next page

Conditions of enrollment *(continued)*

5. I understand that, with certain exceptions described in the plan documents, HMO and DMO© plans only provide coverage for network covered benefits. The plan documents also describe if I need a referral for certain procedures, and who can provide care. Covered services must be performed by:
   - Participating primary care physicians
   - Participating primary care dentists
   - Participating specialists
   - Participating hospitals
   - Participating pharmacies
   - Participating dentists
   - Other participating providers as authorized by a referral from a participating primary care physician
6. I authorize the substitution of generic pharmaceuticals for the brand-name products, as provided by law, for prescriptions filled under any pharmacy benefit.

I represent that to the best of my knowledge and belief all information supplied in this form is true and complete. I have read and agree to the conditions of enrollment and misrepresentation on this **New York** small group business employee enrollment / change form.

I understand that if I do not sign this form within 31 days, I will be considered a late enrollee and the effective date of coverage for me and my dependents may be affected.

I am employed by the employer shown on page 1, and I am working full time at least 20 hours a week for this employer at the regular place of business. I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments as required for coverage.

To receive documents online, please visit your secure member account at http://www.aetna.com.

Misrepresentation: 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 also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Please sign here ONLY if you are enrolling in coverage for yourself and / or dependents. ***Employee signature*** ***X***	***Employee email***	***Date (Month/Day/Year)***
Spouse / domestic partner signature ***X***		***Date (Month/Day/Year)***
Dependent child over the age of majority ***X***		***Date (Month/Day/Year)***
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This form is attached to and made a part of the group policy.