



# Enrollment/Waiver/Change Request

## Aetna Life Insurance Company

**Instructions:** Refer to the instructions on the back before completing this form.  
**Please Print Clearly.**

### A. To be completed by Employer

<b>Employer Group Information:</b> (To Be Completed by Employer)	Employer Name - Full Name of Business or Organization DoD NAF Health Benefits Program — Air Force		Employer Address (Street, City, State, ZIP Code) - Primary Location of Business or Organization 2261 Hughes Ave, Suite 156, Lackland AFB, TX 78236			
	Effective Date of Action:	Effective Date of Payroll Deduction:	Control — Check One HBP: 866212 AI: 706412 SAD: 620387	Suffix	Account	Plan Number (Refer to A on back)
<b>Change</b> - Check all that apply. Add Dependent(s) Name Change Other Control/Suffix/Acct/Plan		<b>Reason:</b> <div style="border: 1px solid black; height: 50px;"></div>		<b>Remove or Terminate</b> - Check all that apply. Remove Dependent(s) Employee Withdrawal/ Termination Cancel Coverage		
		<b>Reason:</b> <div style="border: 1px solid black; height: 50px;"></div>				

### B. To be completed by Employee – You must complete section B, C, & F if waiving coverage.

### C. Options - Your selection must be offered by your employer.

<b>Social Security Number</b>	Last Name, First Name, M.I.	Home/Cell Phone ( ) ( )	Work Telephone ( ) ( )	<b>Check One:</b> Waive Coverage Medical Only (Choice® POS II)      Medical and Dental (TC) Medical Only (HDHP – Choice® POS II)      Medical and Dental (HDHP – Choice® POS II) Medical Only (Traditional Choice®)      Medical and Dental (HDHP –TC) Medical Only (HDHP – Traditional Choice®)      Aetna Dental only Medical and Dental (Choice® POS II)      Stand Alone Dental only
Home Address	Apt. No. City, State	ZIP Code		
<b>D. Method of Payment</b>				
I elect to pay my share of the cost of group health insurance or elect to pay my employee-pay-all cost of Stand Alone Dental Plan by the payment method elected. Having made this choice, I authorize payroll deductions for that purpose. I have read and agreed to the reverse side of this form.		Employee only	Pre Tax	
		Employee + child(ren)	Post Tax	
		Employee + spouse		
		Employee + family		

### E. Individuals Covered - List individuals for whom you are adding/changing/removing coverage.

\* Provide details for "Yes" responses below.

(A)dd (C)hange (R)emove	Name (First, Middle Initial, Last) (Explain difference in last names in Special Remarks.)	Relationship Code	Use ONLY: H=Husband W=Wife S=Son D=Daughter Y=Sponsored Male X=Sponsored Female (Refer to section E on the back)	Sex M F	Birthdate MM DD YYYY	Social Security Number (If dependent has no SSN, write "None")	Prior Insur. Plan	Other Medical Coverage	Other Rx Drug Coverage	Handi-capped
		Self			/ /		Yes *	Yes *	Yes *	Yes N/A
					/ /					
					/ /					
					/ /					
					/ /					
1. If "Yes" to <b>Prior Insurance Plan</b> and/or <b>Other Medical Coverage</b> above, provide effective dates, name & policy number of insurance carrier, HMO or other source and your <b>Member Identification Number</b> .				3. Does any dependent listed above live at a different address than the employee? IF "Yes," who and what address?      Yes      No						
2. If "Yes" to <b>Other Rx Drug Coverage</b> above, provide effective dates, name & policy number of insurance carrier, HMO or other source and your <b>Member Identification Number</b> .				<b>Special Remarks</b>						

### F. 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/Waiver/Change on the reverse side of this Enrollment/Waiver/Change Request form.	<b>Employee Signature - Required</b> X	Date / /	E-Mail Address	What is your primary language? ¿Cuál es su primer idioma?
	<b>Employer Signature - Required</b> X	Date / /		

## Instructions

### Employer – Complete Sections A and E.

#### Section A - Type of Activity:

- Check box(es) indicating reason(s) for submitting this Enrollment/Change Request.
- Provide Effective Date(s) where requested.
- Check the appropriate control number.
- For Plan Number, refer to the following codes:

#### Active/Disabled/TCC Employees

Plan 201 = CP II with Dental  
Plan 701 = CP II without Dental  
Plan 300 = TC with Dental  
Plan 800 = TC without Dental  
Plan 001 = Stand Alone Dental

#### Retirees Under Age 65

Plan 605 = CP II with Dental  
Plan 606 = CP II without Dental  
Plan 601 = TC with Dental  
Plan 604 = TC without Dental

#### Retirees Age 65 and Over

Plan 655 = CP II with Dental  
Plan 656 = CP II without Dental  
Plan 651 = TC with Dental  
Plan 654 = TC without Dental

### Employee – Complete Sections B – F.

#### Section B - Employee Information:

- Complete **all** information in order for your Enrollment/Change Request to be processed.

**Section C - Options:** Select your medical and/or dental plan or waive coverage. I understand that I will not be permitted to renew the coverage that I have cancelled until my employer offers an open enrollment period, unless I meet the conditions for a special enrollment period for health insurance coverage.

#### Section D - Election Method of Payment (Flexible Benefits Plan)

I understand that I may elect to pay my share of the cost of employer-sponsored group health insurance with either pre-tax income or after-tax income or elect to pay my employee-pay-all cost of Stand Alone Dental Insurance with pre-tax income or after-tax income (2) that if I elect to pay with pre-tax income, my election will remain in effect until I revoke it; (3) that my right to revoke it is limited to certain specific circumstances, including, but not limited to, an open enrollment period each year which will be announced by my Human Resources Office; (4) that while my election remains in effect, I may not terminate my group health insurance coverage; and (5) that if I do not make an election, my share of the cost will be paid with after-tax income.

- Pre-tax - I elect to pay my share of the cost of group health insurance or elect to pay my employee-pay-all cost of Stand Alone Dental Plan with pre-tax income. Having made this choice, I authorize pre-tax payroll deductions for that purpose.
- Post-tax - I elect to pay for my share of the cost of group health insurance or elect to pay my employee-pay-all cost of Stand Alone Dental Plan with after-tax income. Having made this choice, I authorize traditional after-tax deduction for that purpose.
- Single rate pre-tax and the difference between single and family rate post-tax - I elect to pay my employee-single rate cost of my DoD HBP with pre-tax income. Having made this choice, I authorize pre-tax payroll deductions for that purpose. I acknowledge the difference between the single and family rates will be calculated as post-tax. This method of payment is not available for the Stand Alone Dental Plan.

#### Section E - 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 Sex, Birthdate, and Social Security Number for each individual listed.
- Under Relationship Code, examples of Sponsored Male (Y) and Sponsored Female (X) include foster children or legal guardianship.
- If you or your dependent(s) were covered under your employer's or other **Prior Insurance Plan** or currently have **Other Medical Coverage**, check the "Yes" box(es) and provide beginning and ending effective dates, name and policy number of insurance carrier, HMO or other source and your **Member Identification Number** in the space provided in Number 1.
- If you or your dependent(s) have **Other Rx Drug Coverage**, check the "Yes" box and provide beginning and ending effective dates, name and policy number of insurance carrier, HMO or other source and your **Member Identification Number** in the space provided in Number 2.
  - **NOTE:** In some instances your medical carrier will differ from your Rx Drug carrier.
- If a dependent is Handicapped and financially dependent, check "Yes" and provide proof of handicapped status from the attending physician.

While the Federal Patient Protection and Affordable Care Act generally 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.

#### Section F - Signature:

- Employer and Employee must sign and date the form.

## 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 an Aetna plan coverage is underwritten or administered by Aetna Life Insurance Company (referred to as "Aetna").
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/Waiver/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/Waiver/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 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.

### 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 intentional misrepresentation of material fact or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.