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 Employee – You must complete section A, B, & F if waiving coverage.

Social Security Number	Last Name, First Name, M.I.		Home/Cell Phone ( )	Work Telephone ( )
Home Address		Apt. No.	City, State	ZIP Code

B. Options - Your selection must be offered by your employer.

Check One: ☐ **WAIVE COVERAGE**

- ☐ Medical Only (Choice® POS II)
- ☐ Medical Only (HDHP – Choice® POS II)
- ☐ Medical Only (Traditional Choice®)
- ☐ Medical Only (HDHP – Traditional Choice®)
- ☐ Medical and Dental (Choice® POS II)
- ☐ Retired
- ☐ Medical and Dental (TC)
- ☐ Medical and Dental (HDHP – Choice® POS II)
- ☐ Medical and Dental (HDHP –TC)
- ☐ Aetna Dental only
- ☐ Stand Alone Dental only

C. Method of Payment

My share of the cost of group health insurance or my employee-pay-all cost of Stand Alone Dental Plan will be deducted from my paycheck on a pre-tax basis as noted. I authorize payroll deductions for that purpose. I have read and agreed to the reverse side of this form.

- ☐ Employee only
- ☐ Employee + child(ren)
- ☐ Employee + spouse
- ☐ Employee + spouse + child(ren)

D. 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**	**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**
			☐ ☐	/ /		☐	☐	☐	☐
			☐ ☐	/ /		☐	☐	☐	☐
			☐ ☐	/ /		☐	☐	☐	☐
			☐ ☐	/ /		☐	☐	☐	☐

Use **ONLY**:
H=Husband
W=Wife
S=Son
D=Daughter
Y=Sponsored Male
X=Sponsored Female
(Refer to section D on the back)

1. If "Yes" to **Prior Insurance Plan** and/or **Other Medical Coverage** above, provide effective dates, name & policy number of insurance carrier, HMO or other source and your **Member Identification Number**.

2. If "Yes" to **Other Rx Drug Coverage** above, provide effective dates, name & policy number of insurance carrier, HMO or other source and your **Member Identification Number**.

3. Does any dependent listed above live at a different address than the employee? If "Yes," who and what address? ☐ Yes ☐ No

Special Remarks

E. To be completed by Employer

Employer Group Information:
(To Be Completed by Employer)

Employer Name - Full Name of Business or Organization	Employer Address (Street, City, State, ZIP Code) - Primary Location of Business or Organization
DoD NAF Health Benefits Program — **NEXCOM**	3280 Virginia Beach Blvd., VA Beach, VA 23452

Effective Date of Action:	Effective Date of Payroll Deduction:	Control — Check One ☐ HBP: 866216 ☐ AI: 706416 ☐ SAD: 620387	Suffix	Account	Plan Number (Refer to A on back)

Change - *Check all that apply.*

- ☐ Add Dependent(s)
- ☐ Name Change
- ☐ Address Change
- ☐ Other

Reason:

Remove or Terminate - *Check all that apply.*

- ☐ Remove Dependent(s)
- ☐ Employee Withdrawal/Termination
- ☐ Continue Health Coverage (i.e. TCC)
- ☐ Cancel Coverage

Reason:

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.

Employee Signature - *Required* **X**	Date / /	E-Mail Address	What is your primary language? ¿Cuál es su primer idioma?
Employer Signature - *Required* **X**	Date / /		

Please make a copy for your records.

Instructions

Employer - Complete **Sections D 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	**Retirees Under Age 65**	**Retirees Age 65 and Over**
Plan 201 = CP II with Dental	Plan 605 = CP II with Dental	Plan 655 = CP II with Dental
Plan 701 = CP II without Dental	Plan 606 = CP II without Dental	Plan 656 = CP II without Dental
Plan 300 = TC with Dental	Plan 601 = TC with Dental	Plan 651 = TC with Dental
Plan 800 = TC without Dental	Plan 604 = TC without Dental	Plan 654 = TC without Dental
Plan 400 = Dental only	Plan 602 = Dental only	Plan 652 = Dental only
Plan 001 = Stand Alone Dental		

Employee - Complete Sections B - F.

Section A - Employee Information:

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

Section B - 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 C - Method of Payment:
I understand that my share of the cost of group health insurance or my employee-pay-all cost of Stand Alone Dental Plan will be deducted from my paycheck as noted and that my election will remain in effect until I revoke it; 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; and that while my election remains in effect, I may not terminate my group health insurance coverage.

- Pre-tax -My share of the cost of group health insurance or my employee-pay-all cost of Stand Alone Dental Plan will be deducted from my paycheck on a pre-tax basis. I authorize payroll deductions for that purpose.

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 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.