Banner | aetna

Small Group Employee Enrollment/Change Form

aetna

Banner Health and Aetna Health Insurance Company **Aetna Life Insurance Company**

Banner Health and Aetna Health Plan Inc. **Aetna Health Inc.**

INSTRUCTIONS: You 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 B.** Please use only black ink to complete this form.

Group number

Member ID number (if available)

Company name Alan D Lepak

Effective date

12/15/2022

Date of hire

Leave blank if unknown.

- ☐ 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 date _____
- ☐ Remove spouse
- ☐ Remove domestic partner
- ☐ Remove dependent child
- ☐ Cancel coverage
- ☐ Other _____

☐ **COBRA** ☐ **State 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. Please print clearly.*

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
( ) -	( ) -		

Salary

$ _____

- ☐ Hourly
- ☐ Weekly
- ☐ Monthly

Number of hours worked a week

Check one:

- ☐ Full time
- ☐ Part time
- ☐ 1099
- ☐ Retiree
- ☐ Seasonal
- ☐ Temporary
- ☐ COBRA
- ☐ Union

Fill out all of section A whether you are enrolling or declining.

B. Declining coverage – *Check all that apply.*

Fill out Section B if you are declining

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: ☐ Medical ☐ Dental ☐ Vision
- ☐ Domestic partner: ☐ Medical ☐ Dental ☐ Vision
- ☐ Children: ☐ Medical ☐ Dental ☐ Vision

Reason for declining coverage

- ☐ Parental group coverage
- ☐ Spouse group coverage
- ☐ Domestic partner group coverage
- ☐ Medicare
- ☐ Medicaid
- ☐ Retiree coverage
- ☐ COBRA coverage
- ☐ Insurance through another job
- ☐ TRICARE / Military coverage
- ☐ Individual coverage – On Exchange
- ☐ Individual coverage – Off Exchange
- ☐ Another group plan provided by my employer
- ☐ Do not want
- ☐ Other _____

I certify I have been given the right to apply for this coverage. However, I am declining coverage as noted above. 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.

☐ I am declining coverage. **Employee signature:** X

Date (Month/Day/Year)

Please PRINT employee name:

C. Coverage selection

Fill out Section C if you are enrolling. Select ONE policy.

Control/Group number	Suffix	Account	Plan number	Class code

1. Medical ☐ Yes ☐ No *To enroll, check one and enter the plan option elected following the plan type below.*

- ☐ Banner Perf OAMP – Plan option AZ Banner Perf Bronze 8400, AZ Banner Perf Gold OAMP 1500 or AZ Banner Perf Silver 4500
- ☐ Banner Perf OAMP – HSA Compatible – Plan option _____
- ☐ Banner Broad PPO – Plan option AZ Banner Broad PPO Gold 2500
- ☐ Banner Broad PPO – HSA Compatible – Plan option _____
- ☐ Banner OOS Broad PPO – Plan option _____
- ☐ Other – Plan option _____

Banner Health and Aetna Health Plan Inc. underwrite the Banner HMO plans. Banner Health and Aetna Health Insurance Company underwrite the Banner Open Access Managed Plus plans, Banner PPO plans and Banner Indemnity plans. Aetna Life Insurance Company underwrites the Other plan options and will provide medical coverage for those members not eligible for Banner|Aetna medical plan options.

Control/Group number	Suffix	Account	Plan number

2. Dental ☐ Yes ☐ No *To enroll, enter the plan number and name below.*

Non-voluntary plans – Plan number _____ Plan name _____

If FOC, choose: ☐ Managed Dental *or* ☐ PPO

Voluntary plans – Plan number _____ Plan name _____

If FOC, choose: ☐ Managed Dental *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 Health Inc. underwrites Aetna dental DMO® plans. Aetna Life Insurance Company underwrites all other Aetna dental plans.

Control/Group number	Suffix	Account	Plan number

3. 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.

We do NOT offer vision and dental through Aetna. Do not fill out Section 2, numbers 2 & 3.

D. 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	☐ Add ☐ Change ☐ Remove	**Employee name** (Last, first, middle initial) Fill out your information in the highlighted sections.	Sex (M/F)
Birthdate (MM/DD/YYYY) / /	Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally separated	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision	
Primary care physician (PCP) provider ID number	Current patient ☐ Yes	Dental provider office ID number	Current patient ☐ Yes

2	☐ Add ☐ Change ☐ Remove	**Name** (Last, first, middle initial) ☐ **Spouse** ☐ **Domestic partner** Fill this section out for your spouse or domestic partner.	Sex (M/F)	Social Security number
Birthdate (MM/DD/YYYY) / /		Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision		
PCP provider ID number	Current patient ☐ Yes	Dental provider office ID number		Current patient ☐ Yes

3	☐ Add ☐ Change ☐ Remove	**Name** (Last, first, middle initial) ☐ **Child** ☐ **Stepchild** ☐ **Other** _____ Fill out this section for a dependent. Add additional dependents below.	Sex (M/F)	Social Security number
Birthdate (MM/DD/YYYY) / /	Incapacitated ☐ Yes ☐ No	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision		
PCP provider ID number	Current patient ☐ Yes	Dental provider office ID number		Current patient ☐ Yes

4	☐ Add ☐ Change ☐ Remove	**Name** (Last, first, middle initial) ☐ **Child** ☐ **Stepchild** ☐ **Other** _____	Sex (M/F)	Social Security number
Birthdate (MM/DD/YYYY) / /	Incapacitated ☐ Yes ☐ No	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision		
PCP provider ID number	Current patient ☐ Yes	Dental provider office ID number		Current patient ☐ Yes

5	☐ Add ☐ Change ☐ Remove	**Name** (Last, first, middle initial) ☐ **Child** ☐ **Stepchild** ☐ **Other** _____	Sex (M/F)	Social Security number
Birthdate (MM/DD/YYYY) / /	Incapacitated ☐ Yes ☐ No	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision		
PCP provider ID number	Current patient ☐ Yes	Dental provider office ID number		Current patient ☐ Yes

6	☐ Add ☐ Change ☐ Remove	**Name** (Last, first, middle initial) ☐ **Child** ☐ **Stepchild** ☐ **Other** _____	Sex (M/F)	Social Security number
Birthdate (MM/DD/YYYY) / /	Incapacitated ☐ Yes ☐ No	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision		
PCP provider ID number	Current patient ☐ Yes	Dental provider office ID number		Current patient ☐ Yes

E. Dependent information

Fill out section E and F if needed.

List any dependent in section **D** with a different last name or living at another address.

Name	Address

F. Coordination of benefits

Will you have other health insurance at the same time as this coverage? ☐ Yes ☐ No

If **yes**, will the Banner|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 and authorizations

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

- *Banner Health and Aetna Health Plan Inc. underwrite the Banner HMO plans.*
- *Banner Health and Aetna Health Insurance Company underwrite the Banner Open Access Managed Plus plans, Banner PPO plans and Banner Indemnity plans.*
- *Aetna Health Inc. underwrites the Aetna dental DMO® plans.*
- Aetna Life Insurance Company underwrites the Other medical plan options, Aetna vision plans and all other dental plans.

1. My employer's application determines coverage. I don't have coverage until Banner|Aetna approves my employee enrollment form and the employer application. Even if Banner|Aetna approves the employer application, any misstatements or omissions may result in denial of future claims. Banner|Aetna may rescind or reevaluate my coverage under the policy, as of the effective date, for eligibility and rating purposes. If Banner|Aetna voids or rescinds coverage, I may be entitled to a refund of any paid premiums from the effective date of coverage. Banner|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, Banner|Aetna may need information about medical history, services or treatment provided to anyone listed on this form. This may include information about mental health and substance use disorder. I authorize that the following entities can provide this information to Banner|Aetna or its agents:
   - Physicians
   - Other healthcare professionals
   - Hospitals
   - Other healthcare organizations ("providers"), including
     - Pharmacies
     - Pharmacy database benefit managers
3. I authorize Banner|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 30 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 Banner|Aetna at any time. I can't revoke authorization for information already used or disclosed before I revoked my authorization. I or my authorized representative are entitled to receive a copy of this authorization upon request. A photocopy is as valid as the original.

Continued on next page

Conditions of enrollment and authorizations *(Continued)*

- 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 Banner|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.

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.
7. I authorize deductions from my earnings for any contributions required for coverage, and I agree to make any necessary payments as required for coverage.

I represent that all information supplied in this form is true and complete. I have read and agree to the Conditions of enrollment and authorizations on this Employee Enrollment / Change Form. I understand that if I don't sign this form within 31 days or Banner|Aetna does not receive the transaction request within a reasonable time, my eligibility may be affected. I am employed by the employer shown on page 1. I am working full time at least 30 hours a week for this employer at the regular place of business.

The undersigned applicant and the agent certify that the applicant has read, or had read to him, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in the loss of coverage under the policy.

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

Please sign here ONLY if you are enrolling in coverage for yourself and / or dependents. ***Employee signature*** **X**	***Employee email***	***Date (Month/Day/Year)***

Don't forget to sign the form!