Virginia Small Group Employee Enrollment/Change Form

☐ **Innovation Health Insurance Company**
☐ **Innovation Health Plan, Inc.**
☐ **Aetna Life Insurance Company**

"Innovation Health" is the brand name used for products and services provided by one or more of the Innovation Health group of subsidiary companies.
"Aetna" is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies.

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 Innovation Health / Aetna member ID number (if available)

Company name			
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 date _____ ☐ Remove spouse ☐ Remove domestic partner ☐ Remove dependent child ☐ Cancel coverage ☐ Other _____
☐ **Consolidated Omnibus Budget Reconciliation Act (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.***

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

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

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

☐ Employee:	☐ Medical ☐ Vision	☐ Dental
☐ Spouse:	☐ Medical ☐ Vision	☐ Dental
☐ Domestic partner:	☐ Medical ☐ Vision	☐ Dental
☐ Children:	☐ Medical ☐ Vision	☐ Dental

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 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 – ***Please print clearly. (Top boxes for employer and Innovation Health / Aetna use only.)***

Control/Group number	Suffix	Account	Plan number	Class code

1. Medical ☐ Yes ☐ No

☐ **VA IH Open Health Maintenance Organization (HMO)** – Plan option _____

☐ **VA IH Preferred Provider Organization (PPO)** – Plan option _____

☐ **VA IH PPO – Health Savings Account (HSA) Compatible** – Plan option _____

Innovation Health Insurance Company *underwrites VA IH Preferred Provider Organization (PPO) plan and VA IH PPO Health Savings Account (HSA) Compatible plan.* ***Innovation Health Plan, Inc.*** *underwrites VA IH Open HMO plan. "Innovation Health" is the brand name used for products and services provided by one or more of the Innovation Health group of subsidiary companies.* ***Aetna Life Insurance Company*** *will provide medical coverage for those members or dependents outside Virginia, the District of Columbia and Maryland.*

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 Freedom-of-Choice (FOC), choose: ☐ Dental Network Only (DNO)* *or* ☐ PPO

Voluntary plans – Plan number _____ Plan name _____

If Freedom-of-Choice (FOC), choose: ☐ DNO* *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

**DNO (Dental Network Only) in Virginia is not an HMO. To receive maximum benefits, members must choose a participating primary dentist to coordinate their care with in-network providers.*

Aetna Life Insurance Company *underwrites Aetna DNO and Dental Preferred Provider Organization (PPO) plans.*

Control/Group number	Suffix	Account	Plan number

3. Aetna Vision℠ Preferred ☐ Yes ☐ No

Aetna Life Insurance Company *underwrites Aetna Vision℠ Preferred plans. First American Administrators, Inc. provides certain claims administration services. EyeMed Vision Care, Limited Liability Corporation (LLC) ("EyeMed") provides certain network administration services.*

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)	Sex (M/F)
Birthdate Month/Day/Year (MM/DD/YYYY) / /	Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally separated	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision	
Primary care physician (PCP) provider identification (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**	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** _____	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

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 Innovation Health / 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:

- VA IH Open HMO plans: Innovation Health Plan, Inc.
- VA IH PPO plans: Innovation Health Insurance Company
- Dental DNO and Dental PPO plans: Aetna Life Insurance Company
- Vision plans: Aetna Life Insurance Company. First American Administrators, Inc. provides certain vision claims administration services. EyeMed Vision Care, LLC ("EyeMed") provides certain network administration services.

1. My employer's application determines coverage. I don't have coverage until Innovation Health and / or Aetna approves my employee enrollment form and the employer application. Even if Innovation Health and / or Aetna approve the employer application, any misstatements or omissions may result in denial of future claims and Innovation Health and / or Aetna may rescind my coverage under the policy, as of the effective date, for an act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact, as prohibited by the terms of the plan. If Innovation Health and / or Aetna voids or rescinds coverage, I may be entitled to a refund of any paid premiums from the effective date of coverage. Innovation Health and / or 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 underwrite the coverages listed in the coverage selection section on page 2, Innovation Health and / or Aetna may need minimally necessary information about medical history, services or treatment provided to anyone listed on this form. This may include information about mental health, substance use disorder and Human Immunodeficiency Virus (HIV) / Acquired Immune Deficiency Syndrome (AIDS). I authorize that the following entities can provide this information to Innovation Health and / or Aetna or its agents:
   - Physicians
   - Other healthcare professionals
   - Hospitals
   - Other healthcare organizations ("providers"), including
     - Pharmacies
     - Pharmacy database benefit managers
3. I authorize Innovation Health and / or Aetna underwriting the coverages checked in section C on page 2, to use and disclose the minimally necessary information listed in the paragraph above 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

Continued on next page

Conditions of enrollment

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 Innovation Health and / or 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, 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 Innovation Health and / or 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 DNO plans only provide coverage for 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 all information supplied in this form is true and complete. I have read and agree to the conditions of enrollment, authorizations and misrepresentation on this Employee Enrollment / Change Form. I understand that if I fail to sign this form within 31 days or Innovation Health and / or Aetna (as applicable) does not receive the 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. I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments required for coverage.

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

Misrepresentation: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

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

Employee email	*In enrolling in an HMO / Open HMO or DNO plan, I acknowledge that a PPO or dental PPO plan has been offered to me.* ☐ Yes ☐ No

Insurance agent signature	***Date (Month/Day/Year)***
X	