NOTE: ***Before you return this form to your employer, you may wish to tape or staple the form so that health information is not visible. This will help keep your health information private.***

innovation HEALTH℠ Aetna | Inova PARTNERSHIP

Virginia Employee Enrollment/Change Form

FOR GROUP COVERAGE (51 - 100 ELIGIBLE EMPLOYEES)

aetna®

Innovation Health Insurance Company
Innovation Health Plan, Inc.

Aetna Life Insurance Company

VA IH Preferred Provider Organization (PPO) plan and VA IH PPO Health Savings Account (HSA) Compatible plan are underwritten by **Innovation Health Insurance Company**. VA IH Open Health Maintenance Organization (HMO) plan, VA IH Open HMO Health Savings Account (HSA) Compatible plan, VA IH Open HMO Option plan, VA IH Open HMO Option Health Savings Account (HSA) Compatible plan, VA IH Open HMO Option HRA plan, VA IH HMO plan and VA IH HMO Health Savings Account (HSA) Compatible plan are underwritten by **Innovation Health Plan, Inc.** "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.

Aetna Vision℠ Preferred plans are underwritten by **Aetna Life Insurance Company**. Aetna DNO* and Dental Preferred Provider Organization (PPO) plans are underwritten by **Aetna Life Insurance Company.** For Vision coverage, certain claims administration services are provided by First American Administrators, Inc. and certain network administration services are provided through EyeMed Vision Care LLC ("EyeMed"). "Aetna" is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies.

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

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** **Benefit waiting period*** ☐ Class 1 ☐ Class 2 * Only required when your employer has 2 benefit waiting periods	☐ 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** 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 ☐ Part time	☐ 1099 ☐ Retiree	☐ Seasonal ☐ Temporary	☐ COBRA ☐ 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
☐ Child(ren):	☐ 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 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 dependent(s). | ***Date (Month/Day/Year)***

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

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 *To enroll, check one and enter the plan option elected following the plan type below.*

☐ **VA IH Open HMO** – Plan option _____
☐ **VA IH Open HMO** – **HSA Compatible** – Plan option _____
☐ **VA IH Open HMO Option** – Plan option _____
☐ **VA IH Open HMO Option** – **HSA Compatible** – Plan option _____
☐ **VA IH Open HMO Option HRA** – Plan option _____
☐ **VA IH HMO** – Plan option _____
☐ **VA IH HMO** – **HSA Compatible** – Plan option _____
☐ **VA IH PPO** – Plan option _____
☐ **VA IH PPO** – **HSA Compatible** – Plan option _____

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: ☐ DNO *or* ☐ PPO

Voluntary plans – Plan number _____ Plan name _____
If 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

Control/Group number	Suffix	Account	Plan number

3. Vision ☐ Yes ☐ No
Aetna Vision℠ Preferred

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 (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**		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

G. Medicare information

Name of person	Medicare Part A	Medicare Part B	Medicare Part D	Over age 65	Disability	End-stage renal disease effective date
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

Conditions of enrollment

On behalf of myself and the dependents listed, I agree to or with the following:

1. I acknowledge that by enrolling in the following plans, coverage is provided by the following entities:
   - VA IH HMO and VA IH Open HMO plans: Innovation Health Plan, Inc.
   - VA IH PPO plans: Innovation Health Insurance Company
   - Dental DNO and PPO plans: Aetna Life Insurance Company
   - Aetna Vision plans: Aetna Life Insurance Company; certain claims administration services are provided by First American Administrators, Inc. and certain network administration services are provided through EyeMed Vision Care, LLC ("EyeMed").

   "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 is referred to as "Aetna".
2. I understand and agree that my employer's application will determine coverage and that there is no coverage unless and until both the eligible employee enrollment form and employer application have been accepted and approved by Innovation Health and / or Aetna as applicable. Even if this application is approved, any misstatements or omissions may result in future claims being denied and the policy or my coverage under the policy being rescinded or reevaluated, as of the effective date, for eligibility and rating purposes. I may also be entitled to a refund of any paid premiums from the effective date of coverage if coverage is voided or rescinded. Innovation Health and / or Aetna will provide at least 30 days written notice or electronic notice (if you have elected electronic notice) to any covered person who would be affected by the proposed rescission of coverage before coverage under the plan is rescinded, regardless of whether the rescission applies to the entire group or only to an individual within the group.
3. I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("providers"), including pharmacies and / or pharmacy database benefit managers, to give to the Innovation Health and / or Aetna as applicable company(ies) underwriting coverage(s) for the product(s) checked in the Coverage selection section on page 2, or its (their) agent(s), information concerning the medical history, services or treatment provided to anyone listed on this Application, including those involving mental health, substance use disorder and HIV / AIDS. I further authorize Innovation Health and / or Aetna as applicable 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. This authorization is applicable to the Innovation Health and / or Aetna company(ies) underwriting coverage(s) for the product(s) checked in section C on page 2. I have discussed the terms of this authorization with my spouse or domestic partner and competent adult dependents, and I have obtained their consent to those terms. This authorization will remain valid for 30 months from the date I signed it or in the case of the information described above being collected in connection with a medical claim, this authorization will be valid for the term of the coverage. I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original. This authorization is voluntary. However, I understand that if I refuse to sign this authorization form, my ability to enroll in the plans described above may be affected. I have the right to revoke this authorization in writing to Innovation Health / Aetna at any time except to the extent that my information has already been used or disclosed in reliance on this authorization. However, because this information is essential to the administration of the plans, I understand that my revocation of this authorization may result in cancellation of my enrollment in the plans described above.

Continued on next page

Conditions of enrollment *(Continued)*

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® and Aetna Specialty Pharmacy®, all participating providers and vendors are independent contractors and are neither agents nor employees of Innovation Health and / or Aetna as applicable. Aetna Rx Home Delivery®, LLC, and Aetna Specialty Pharmacy, LLC, are subsidiaries 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.
6. I understand and agree that, with certain exceptions described in the plan documents, HMO and DNO plans only provide coverage for referred benefits, and that, in order to be covered, services must be performed either by a participating primary care physician, primary care dentist, or by the participating specialist, hospital, pharmacy, dentist, or other provider as authorized by a referral from a participating primary care physician.

Authorization

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.
8. I authorize the substitution of generic pharmaceuticals for the brand-name products, as provided by law, for prescriptions filled under any pharmacy benefit.

Misrepresentation

9. 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. We will provide at least 30 days' advance written notice or electronic notice to any covered person who would be affected by the proposed rescission of coverage before coverage under the plan is rescinded, regardless of whether the rescission applies to the entire group or only to an individual within the group.

I represent that all information supplied in this form both above and below this signature block 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, in the event I fail to sign this form within 31 days after the above transaction request or for any reason Innovation Health and / or Aetna as applicable does not receive notice of the above transaction request within a reasonable time following the event, my eligibility and my dependents' eligibility may be affected. I am employed by the employer shown on page 1, and 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.

If you wish to receive documents online, please visit your secure member account at http://www.innovation-health.com

Please sign here ONLY if you are enrolling in coverage for yourself and / or dependent(s).	***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	

Company name:	
Employee name:	

H. Health questionnaire must be completed for all individuals enrolling for coverage.

Health history for you and your dependents. ***The following information is confidential and will not be seen by or given to your employer.***
You or your dependents must answer ALL of the questions. Incomplete enrollment forms may delay the date your coverage starts.

1. Within the last **five** years, has anyone applying for coverage consulted with or received treatment from a doctor, psychiatrist, psychologist, or other practitioner or been diagnosed with any of the following conditions or disorders? (Check all that apply.) ☐ Yes ☐ No

a. ☐ Diabetes
b. ☐ Infertility
c. ☐ Endocrine/ metabolic
d. ☐ Pancreas
e. ☐ Liver / hepatitis
f. ☐ Immune system
g. ☐ Blood disorder
h. ☐ Hemophilia
i. ☐ Epilepsy / seizure
j. ☐ Heart
k. ☐ Paralysis / paresis
l. ☐ Tumor / cyst / growth
m ☐ Systemic or discoid lupus
n. ☐ Lung or respiratory
o. ☐ Alcohol or drug use
p. ☐ Kidney / bladder / urinary
q. ☐ Circulatory / vascular
r. ☐ Digestive / stomach / intestinal
s. ☐ Central nervous system
t. ☐ Connective tissue disorder
u. ☐ Pituitary / adrenal / growth disorder
v. ☐ Birth defects / congenital abnormalities
w. ☐ Arthritis / bone / joint / muscle / prosthetic device
x. ☐ Mental / nervous / emotional / eating disorder
y. ☐ Stroke / brain / neurological
z. ☐ Transplant: ☐ Recommended ☐ Pending ☐ Complete
aa. ☐ Advised to have ☐ Tests, ☐ Surgery, ☐ Hospitalization or is ☐ treatment needed, or ☐ course of treatment not yet determined
bb. ☐ Cancer: Type:_____ Stage _____ ☐ Surgery ☐ Chemo ☐ Radiation
cc. ☐ Using: ☐ Crutches ☐ Walker ☐ Wheelchair
dd. ☐ Other _____

2.	Has any person listed on this enrollment form tested positive for exposure to the human immunodeficiency virus (HIV) or been diagnosed with acquired immune deficiency syndrome (AIDS) caused by HIV or other sickness or condition derived from this infection? Or has any person listed on this enrollment form been diagnosed with AIDS-related complex (ARC)?	☐ Yes ☐ No
3.	Is anyone currently pregnant? Due date _____ Check applicable boxes: ☐ C section planned ☐ Multiple births expected (Number _____) ☐ Complications: ☐ Past or ☐ Present	☐ Yes ☐ No
4.	Has anyone applying for coverage had more than $5,000 in medical expenses in the past 24 months?	☐ Yes ☐ No
5.	Has anyone applying for coverage been prescribed medications in the past 12 months?	☐ Yes ☐ No
6.	Does anyone applying for coverage have a known condition that requires ongoing treatment?	☐ Yes ☐ No

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS IN SECTION H, YOU MUST COMPLETE SECTIONS I and J.

I. Health questionnaire – Details for "Yes" answers in Section H.

List all individuals enrolling for coverage. Name	Age	Height	Weight	Cigarette smoker	Currently taking prescription medication(s)
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No

J. Provide details below to any boxes checked above. (If additional space is needed, attach a separate sheet and be sure to sign and date the sheet.)

Ques. No.	Name	Condition / diagnosis / treatment	Date of onset	Date treatment ended	Names of prescription medication	Dosage	Still taking medication
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

Employee signature (required)	*Date (Month/Day/Year)*