Employee Enrollment/Change Request

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

Instructions: *Refer to the instructions on the back before completing this form. You must complete this application in full or it will be returned to you resulting in a delay in processing. You are solely responsible for its accuracy and completeness.*

Control	Suffix	Account	Plan Number
Group Number			Class Code

Employer Group Information (To Be Completed by Employer)

Group/Employer Name – Full Name of Business or Organization

A. Type of Activity – Employee Completes Sections A – E. *Please Print Clearly.*

Enrollment
☐ New Enrollee/Subscriber

Effective Date:
_____/_____/_____

Date of Hire:
_____/_____/_____

Change – *Check all that apply.*
☐ Add Spouse
☐ Add Child
☐ Name Change
☐ Other _____
☐ Change Plan:
_____
☐ Control/Suffix/Acct/Plan:
_____
Date of Event: ____/____/_____
Reason: _____

Remove or Terminate –
Check all that apply.
☐ Remove Spouse
☐ Remove Child
☐ Employee Withdrawal/ Termination

Effective Date: ____/____/_____
Reason: _____

Continuation of Coverage, i.e., COBRA, State
Not all options are available. Contact Employer for available options.
Coverage for: ☐ Employee ☐ Dependents
Length of Continuation (months):
☐ 18 ☐ 36 ☐ Other _____
☐ 29 – Attach disability determination from the Social Security Administration
Date of Loss of Coverage: ____/____/_____
Date of Qualifying Event: ____/____/_____
Continuation of Coverage Expiration Date:
____/____/_____

B. Employee Information

Social Security Number	Last Name, First Name, M.I.		Home Telephone
Home Address	Apt. No.	City, State	ZIP Code
Employer Name			Work Telephone
Work Address		City, State	ZIP Code

C. Plan Options – Your selection(s) must be offered by your employer.

☐ HMO ☐ Open HMO
☐ POS ☐ Open HMO Option
☐ Open POS

These Plans are underwritten by Innovation Health Plan, Inc.

Indicate Plan Name

Primary Copay
☐ $5 ☐ $10
☐ $15 ☐ Other $ _____

While the Federal Patient Protection and Affordable Care Act generally mandates coverage of children up to age 26, your plan may allow coverage up to age 26 and beyond. Please refer to your plan documents or contact your benefits administrator.

D. Individuals Covered - *List individuals for whom you are enrolling or adding/changing/removing coverage.*

Provide details for "Yes" responses below.

(A)dd (C)hange _____ (R)emove	1. Employee Name (Last, First, M.I.)				Sex (M/F)	Birthdate (MM/DD/YYYY) / /	
Social Security Number	Other Medical Coverage Yes* ☐	Other Rx Drug Coverage Yes* ☐	Handicapped N/A	Primary Medical Office ID Number	Current Patient Yes ☐	Dental Office ID Number (if applicable)	Current Patient Yes ☐

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Employee copy may be used as a temporary ID card for 30 days from the effective date if authorized by employer. Coverage must be verified with Innovation Health prior to visiting a specialist or admission to a hospital.

D. Individuals Covered – (continued) ***List individuals for whom you are enrolling or adding/changing/removing coverage.***
****Provide details for "Yes" responses below.***

(A)dd (C)hange _____ (R)emove	**2. Spouse Name** (Last, First, M.I.)				Sex (M/F)	**Birthdate** (MM/DD/YYYY) / /	
Social Security Number	Other Medical Coverage **Yes*** ☐	Other Rx Drug Coverage **Yes*** ☐	Handicapped **Yes** ☐	Primary Medical Office ID Number	Current Patient **Yes** ☐	Dental Office ID Number (if applicable)	Current Patient **Yes** ☐

(A)dd (C)hange _____ (R)emove	**3. Child Name** (Last, First, M.I.)				Sex (M/F)	**Birthdate** (MM/DD/YYYY) / /	
Social Security Number (if dependent has no SSN, write "None")	Other Medical Coverage **Yes*** ☐	Other Rx Drug Coverage **Yes*** ☐	Handicapped **Yes** ☐	Primary Medical Office ID Number	Current Patient **Yes** ☐	Dental Office ID Number (if applicable)	Current Patient **Yes** ☐

(A)dd (C)hange _____ (R)emove	**4. Child Name** (Last, First, M.I.)				Sex (M/F)	**Birthdate** (MM/DD/YYYY) / /	
Social Security Number (if dependent has no SSN, write "None")	Other Medical Coverage **Yes*** ☐	Other Rx Drug Coverage **Yes*** ☐	Handicapped **Yes** ☐	Primary Medical Office ID Number	Current Patient **Yes** ☐	Dental Office ID Number (if applicable)	Current Patient **Yes** ☐

(A)dd (C)hange _____ (R)emove	**5. Child Name** (Last, First, M.I.)				Sex (M/F)	**Birthdate** (MM/DD/YYYY) / /	
Social Security Number (if dependent has no SSN, write "None")	Other Medical Coverage **Yes*** ☐	Other Rx Drug Coverage **Yes*** ☐	Handicapped **Yes** ☐	Primary Medical Office ID Number	Current Patient **Yes** ☐	Dental Office ID Number (if applicable)	Current Patient **Yes** ☐

(A)dd (C)hange _____ (R)emove	**6. Child Name** (Last, First, M.I.)				Sex (M/F)	**Birthdate** (MM/DD/YYYY) / /	
Social Security Number (if dependent has no SSN, write "None")	Other Medical Coverage **Yes*** ☐	Other Rx Drug Coverage **Yes*** ☐	Handicapped **Yes** ☐	Primary Medical Office ID Number	Current Patient **Yes** ☐	Dental Office ID Number (if applicable)	Current Patient **Yes** ☐

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

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

4. Is your spouse employed? ☐ Yes ☐ No If "Yes," provide name & address of spouse's employer.

E. Race/Ethnicity - Optional (This information is designed for the purpose of data collection & will not be used for determining eligibility, rating or claim payment.)

Employee 1.	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____	**Child 4.**	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____
Spouse 2.	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____	**Child 5.**	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____
Child 3.	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____	**Child 6.**	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____

Conditions of Enrollment

Applicant Acknowledgments and Agreements

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

1. I acknowledge that by enrolling in a medical plan, coverage is underwritten or administered by Innovation Health Plan, Inc. (referred to as "Innovation Health"). Aetna Life Insurance Company will provide medical coverage for those members or dependents outside Virginia, the District of Columbia and Maryland.
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/Change Request may be transmitted to Innovation Health and/or 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 Innovation Health and/or Aetna or its agent information concerning the medical history, services or treatment provided to anyone listed on this Enrollment/Change Request form, including those involving mental health, substance abuse and HIV/AIDS. I further authorize Innovation Health and/or 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. This authorization is applicable to the Innovation Health and/or Aetna company underwriting coverage(s) for the product checked in Section C on page 1. 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 30 months from the date I sign it, or in the case of the information described above being collected in connection with a claim, this authorization will be valid for the term of the coverage. I understand I or my authorized representative is entitled to a copy of this authorization upon request and that a photocopy is as valid as the original.
4. The plan documents (Schedule of Benefits, Group Agreement, Certificate of Coverage, Group Policy, Group Insurance Certificate) 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 Innovation Health and/or Aetna as applicable. 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.
6. As a condition to HMO benefits, I understand and agree that (with the exception of direct access services and emergency procedures as defined in the plan documents) all services, in order to be covered by the Innovation Health Plan, Inc. HMO, must be performed either by a participating primary care physician, or by the participating specialist, hospital, pharmacy, dentist, or other provider as authorized by a prior referral form from a participating primary care physician.

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 materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

☐ *By checking this box you agree to use our member self-service website for all future printed materials and understand you may choose to receive paper documents in the future. To view this material, visit us at www.innovation-health.com.*

Employee 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 on this Enrollment/Change Request form.

If you have questions concerning the benefits and services provided by or excluded under this Agreement, contact a Member Services representative at the number on your ID card before signing this form.

Employee Signature *- Required*	***Date (Month/Day/Year)***	***Employee E-mail Address***	***Primary Language Spoken***
X	/ /		

Instructions

Employer - Complete the **Employer Group Information** at the top of Page 1.

Employee – Complete Sections A – E. Additional dependent and/or other information may be provided on a separate sheet of paper. All attachments must be signed and dated.

Section A – Type of Activity:

- Check box(es) indicating reason(s) for submitting this Enrollment/Change Request.
- Provide Effective Date(s) & Date of Event(s) where requested.

Section B – Employee Information: Complete **all** information in order for your Enrollment/Change Request to be processed.

Section C – Plan Options:

- Your selection(s) must be offered by your employer.
- Where applicable, indicate Plan Option Name & check *one* Primary Copay.

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 names(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, & Social Security Number for each individual listed.
- If you or your dependent(s) have **Other Medical Coverage**, check the "Yes" box and provide beginning & ending effective dates, name & policy number of insurance carrier, HMO or other source & your **Member Identification Number** for the insurance plan 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 & ending effective dates, name & policy number of insurance carrier, HMO or other source & your **Member Identification Number** for the insurance plan 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" & provide proof of handicapped status from the attending physician.
- Primary Medical Office ID Number/Dental Office ID Number: Locate the office ID number for the primary care physician &/or dentist (if applicable) from the appropriate provider directory or from the online provider directory at "www.innovation-health.com".
- If you are a current patient, please check the "Yes" box under Current Patient.

Section E – Race/Ethnicity (Optional): Check the appropriate Race/Ethnicity code for each individual. If your Race/Ethnicity is "Other," print the Race/Ethnicity for each individual in the space provided.

Conditions of Enrollment/Misrepresentation – Employee Signature:

- Employee must sign & date the Enrollment/Change Request for new enrollments or coverage changes to be processed.
- Read the Conditions of Enrollment.