Employee Enrollment/Change Request

Innovation Health Insurance Company | **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 (IMO Only)		Customer Code (Optional)	

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

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

Enrollment – *Check one.*
- ☐ New Enrollee/Subscriber
  - **Effective Date:** ____/____/____
  - **Date of Hire:** ____/____/____
- ☐ Rehire/Reinstatement
  - **Date of Rehire/ Reinstatement** ____/____/____

Change – *Check all that apply.*
- ☐ Add Spouse
- ☐ Add Dependent Child
- ☐ Name Change
- ☐ Other _____
- ☐ Control/Suffix/Acct/Plan: _____

Date of Event: ____/____/____

Reason: _____

Remove or Terminate – *Check all that apply.*
- ☐ Remove Spouse
- ☐ Remove Dependent Child
- ☐ Employee Withdrawal/ Termination
- ☐ Cancel Coverage

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	Work Telephone
Employee Status ☐ Active ☐ Retired	Home Address	Apt. No.	City, State	ZIP Code

Beneficiary information - Complete only if Aetna Life Insurance coverage is offered by your Employer.

Beneficiary Designation – **Full Beneficiary Name** (First, Middle, Last) If more than one beneficiary, use Special Remarks (Section D).

Social Security Number of Beneficiary	Relationship to Employee

Earnings Information
- ☐ Annually $ _____
- ☐ Weekly $ _____
- ☐ Insurance Amount $ _____
- ☐ Supplemental Life $ _____
- ☐ AD&D Amount $ _____

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

Check One:
- ☐ Open POS II
- ☐ HealthFund
- ☐ Open Network Only Plus
- ☐ Open POS Plus
- ☐ PPO
- ☐ Network Only Plus
- ☐ Indemnity

Inside Virginia, District of Columbia and Maryland, medical plan coverage is underwritten by Innovation Health Insurance Company. Outside of Virginia, District of Columbia and Maryland, medical plan coverage is underwritten by Aetna Life Insurance Company.

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.

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

☐ **Check this box if you are refusing coverage for your dependents.** **** Provide details for "Yes*" responses below.***

1	**(A)**dd **(C)**hange ____ **(R)**emove	**Employee Name** - Last, First, M.I.	Relation. Code **Self**	Sex (M/F)	**Birthdate** (MM/DD/YYYY) / /

Social Security Number	Prior Insurance Plan **Yes*** ☐	Other Medical Coverage **Yes*** ☐	Other Rx Drug Coverage **Yes*** ☐	Handicapped **N/A**	Primary Medical Office ID Number	Current Patient **Yes** ☐

Continued on Page 2

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

2	**(A)**dd **(C)**hange ____ **(R)**emove	**Spouse Name** - Last, First, M.I. (Explain difference in last name in Special Remarks.)				Relation. Code	Sex (M/F)	**Birthdate** (MM/DD/YYYY) / /
Social Security Number (if dependent has no SSN, write "None")		Prior Insurance Plan **Yes*** ☐	Other Medical Coverage **Yes*** ☐	Other Rx Drug Coverage **Yes*** ☐	Handicapped **Yes** ☐	Primary Medical Office ID Number		Current Patient **Yes** ☐
3	**(A)**dd **(C)**hange ____ **(R)**emove	**Child Name** - Last, First, M.I. (Explain difference in last name in Special Remarks.)				Relation. Code	Sex (M/F)	**Birthdate** (MM/DD/YYYY) / /
Social Security Number (if dependent has no SSN, write "None")		Prior Insurance Plan **Yes*** ☐	Other Medical Coverage **Yes*** ☐	Other Rx Drug Coverage **Yes*** ☐	Handicapped **Yes** ☐	Primary Medical Office ID Number		Current Patient **Yes** ☐
4	**(A)**dd **(C)**hange ____ **(R)**emove	**Child Name** - Last, First, M.I. (Explain difference in last name in Special Remarks.)				Relation. Code	Sex (M/F)	**Birthdate** (MM/DD/YYYY) / /
Social Security Number (if dependent has no SSN, write "None")		Prior Insurance Plan **Yes*** ☐	Other Medical Coverage **Yes*** ☐	Other Rx Drug Coverage **Yes*** ☐	Handicapped **Yes** ☐	Primary Medical Office ID Number		Current Patient **Yes** ☐
5	**(A)**dd **(C)**hange ____ **(R)**emove	**Child Name** - Last, First, M.I. (Explain difference in last name in Special Remarks.)				Relation. Code	Sex (M/F)	**Birthdate** (MM/DD/YYYY) / /
Social Security Number (if dependent has no SSN, write "None")		Prior Insurance Plan **Yes*** ☐	Other Medical Coverage **Yes*** ☐	Other Rx Drug Coverage **Yes*** ☐	Handicapped **Yes** ☐	Primary Medical Office ID Number		Current Patient **Yes** ☐
6	**(A)**dd **(C)**hange ____ **(R)**emove	**Child Name** - Last, First, M.I. (Explain difference in last name in Special Remarks.)				Relation. Code	Sex (M/F)	**Birthdate** (MM/DD/YYYY) / /
Social Security Number (if dependent has no SSN, write "None")		Prior Insurance Plan **Yes*** ☐	Other Medical Coverage **Yes*** ☐	Other Rx Drug Coverage **Yes*** ☐	Handicapped **Yes** ☐	Primary Medical Office ID Number		Current Patient **Yes** ☐

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 & 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?

Special Remarks:

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 on Pages 1 and 2, 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 Insurance Company (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. 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 medical claim, this authorization will remain valid for the term of the coverage. In the case of a life claim, this authorization will remain valid for the duration of the claim. 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.
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 Innovation Health and/or 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 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. I have read and agree to the Conditions of Enrollment and Misrepresentation on this Employee Enrollment/Change Request form.

Employee Signature *- Required*	***Date (Month/Day/Year)***	***Employee E-mail Address (optional)***	***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. 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.
- *Beneficiary Designation* – Complete only if your employer is offering Aetna Life Insurance coverage.

Section C – Plan Options: Your selection must be offered by your employer.

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.
  - *Relationship Code* – Use **ONLY**: H=Husband, W=Wife, S=Son, D=Daughter, Y=Sponsored Male, X=Sponsored Female. **If the dependent is NOT your spouse or a biological or legally adopted child, please indicate relationship to employee in Special Remarks.**
- 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 & 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: Locate the office ID number for the primary care physician 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.
- By checking the box above your signature, 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.