Employee Name: _____

CBIA/Aetna

Enrollment/Change Form

Thank you for electing coverage from your employer's CBIA/Aetna benefit plan. Review the instructions below and the Acknowledgement on page 4. Then fill out the form with information requested. Remember to elect ONLY coverages offered by your employer. If you have questions, contact your employer's benefit administrator.

INSTRUCTIONS

1. **Enrollment/Change:** Indicate the type of transaction you are requesting and the effective dates.
2. **Employer Information:** Provide the Employer's Name, Telephone Number and CBIA Group Number.
3. **Employee Information:** Provide your Name, Address, Social Security Number, Home and Work Number, Birthdate, Sex, Martial Status, Employee Status, Date of Hire, Rehire or Retirement

   Note: PCP (Primary Care Provider) Information is only required if electing QPOS or HMO medical plans.
4. **Dependent:** Indicate whether you are or are not electing dependent coverage. Provide Dependent's Name, Social Security Number, Birthdate and Relationship
   Code (H=Husband, W=Wife, S=Son, D=Daughter).

   PCP (Primary Care Provider) Name, ID number and if previously seen — **must be completed unless electing QPOS or HMO medical plans.**

4a. Student: If the dependent is a student age 19 or over, provide the name of institution and expected graduation date.

5. **Other Healthcare Coverage:** For Medicare/Medicaid indicate if you or any dependents have other healthcare coverage. If yes, provide all requested information including plan or Medicare/Medicaid numbers.
6. **Plan Selection:** Indicate Single, Employee and Spouse, Employee and Child(ren), Family (employee, spouse and children.)
7. **Medical:** Indicate the plan ***(offered by your employer)*** you are electing.
8. **Dental:** Indicate the plan and coverage level ***(offered by your employer)*** you are electing. Include the name of all dependents being enrolled, date of birth and Social Security Number.
9. **Life/Disability:** Indicate the coverage ***(offered by your employer)*** and amount of insurance you are electing. Provide your current earnings if electing LTD, STD or a salary based Life amount.
10. **Beneficiary Information:** List the first name, middle initial, last name and relationship of the person to whom benefits will be paid in the event of your death. ALWAYS show the beneficiary's proper name; do NOT show as: "Mrs. John J. Smith" or "M. J. Smith". Show as: Mary J. Smith, WIFE.
    Examples: a) "Mary J. Smith – WIFE, if she survives me, otherwise my surviving children", b) "John A. Smith and Susan B. Smith – CHILDREN", c) "Lynn T. Johnson – FRIEND".
11. **Authorization:** Review the authorization section on page 4. If you agree to all the authorizations, **sign and date** the form in the space provided.

Remember to attach your completed Family Health Statement.

Connecticut Public Act 09-46
Medical Loss Ratio for 2015

The medical loss ratio is defined as the ratio of incurred claims to earned premium for the prior calendar year for managed care plans issued in Connecticut and shall otherwise be calculated in accordance with the requirements of Connecticut state law. For calendar year 2015, the medical loss ratio for Aetna is:

Aetna Life Insurance Company	86.0%

CBIA/Aetna Enrollment/Change Form

MEMBER INFORMATION

1. ENROLLMENT/CHANGE

Effective Date:

Enrollment
- ❒ New Group
- ❒ New Employee
- ❒ Existing Employee Newly Eligible
- ❒ Existing Employee: SPECIAL ENROLLMENT*
- ❒ Rehired/Reinstatement of Coverage
- ❒ Add Dependent (provide Date of Event)**
  - _____ Marriage
  - _____ Birth
  - _____ Adoption
  - _____ Loss of Other Coverage*

* (Attach Certificate of Creditable Coverage)

Termination
- ❒ Terminating Employment
- ❒ Canceling Coverage
- ❒ Layoff/Leave of Absence
- ❒ Death
- ❒ Remove Dependent

Termination Date_____

Change (indicate reason)

_____

_____

Continuation-of-Coverage

Attach Continuation-of-Coverage election form
- ❒ Add Employee
- ❒ Add Dependent(s)

Type of Qualifying Event (provide date)
- _____ Termination of Employment/Loss of Eligibility
- _____ Death of Covered Employee
- _____ Divorce or Legal Separation
- _____ Dependent Child Limiting Age
- _____ Loss of Dependent Coverage When Employee Became Entitled to Medicare

2. EMPLOYER INFORMATION

	Employer CBIA Group #
Employer Name	Telephone: ( )

3. EMPLOYEE INFORMATION

Effective Date of Coverage:

Employee Name (Last, First, Middle Initial)	Social Security # - -	Birthdate (M/D/Y)	Employment Status ❒ Active ❒ Retired
Employee Address (Street)	Home Telephone ( )	❒ Male ❒ Female	Employee Date of Hire/Rehire/ Retirement:
Employee Address (City, State, ZIP)	Work Telephone ( )	❒ Single ❒ Married	Part-time to Full-time Employment Date:
Primary Care Provider Name	PCP ID #	Previously Seen? ❒ Yes ❒ No	Check here if Disabled ❒

4. DEPENDENT INFORMATION

(If 19 or over, list dependent below AND also complete Student/Disabled section)

- ❒ I elect coverage for my eligible dependents listed below
- ❒ I refuse coverage for my eligible dependents
- ❒ I do not have eligible dependents

Dependent Name (Last Name, First Name, Middle Initial)	Social Security #	Birthdate M/D/Y	Rel. Code***	PCP Name	PCP State	PCP ID #	Prev. Seen?
							Y / N
							Y / N
							Y / N
							Y / N
							Y / N

4a. Student/Disabled Section

Dependent(s) Age 19 or over (Name)	Full-Time Student	CT Resident	Check here if Disabled	If Full-Time Student, Provide Name of Institution *Attach documentation (letter from Registrar, class schedule or tuition bill).*	Graduation Date (M/Y)
	Y / N	Y / N	❒		
	Y / N	Y / N	❒		

5. OTHER HEALTHCARE COVERAGE, MEDICARE, OR MEDICAID

Do you or any dependent(s) have any other health coverage or Plan?
❒ Yes (If "Yes", indicate plan information below. Also show who is on Medicare Part A, Medicare Part B, or Medicaid) ❒ No

Participant's Name(s):	Name of Carrier or Plan (including Medicare/Medicaid)	Medicare Plan (if applicable)	Carrier, Plan, or Medicare #	Effective Date
		❒ Part A ❒ Part B		
		❒ Part A ❒ Part B		

****See instructions on page 1 for codes.*

Reminder: Attach your completed Family Health Statement to avoid processing delays

6. PLAN SELECTIONS:

Note: Coverage level for Medical and Dental must be the same

Employee Name (Last, First, Middle Initial) | Social Security # - -

Coverage Level: ❒ Single ❒ Employee + Spouse ❒ Employee + Child(ren) ❒ Family

7. MEDICAL

	Request	Refuse/Cancel
1. Medical — Aetna QPOS	❒	❒
2. Medical — Aetna HMO	❒	❒
3. Medical — Medical — Traditional	❒	❒

8. DENTAL

❒ **Waive Dental**

Coverage Level (choose one)
❒ Employee
❒ Employee + Spouse
❒ Employee + Child(ren)
❒ Family

Coverage Level
❒ Dental DMO*
❒ Standard PPO
❒ Enhanced PPO
❒ Passive PPO 1000

❒ Existing employer plan

For Dental coverages, list employee and dependent(s) in the section below.

Employee Name (Last, First, Middle Initial)	Date of Birth	Social Security #	*Dental PCD ID #
(SELF)		- -	
		- -	
		- -	
		- -	

8a. Student/Disabled Section Dependent(s) Age 19 or over (Name)	Full-Time Student	CT Resident	Check here if Disabled	If Full-Time Student, Provide Name of Institution *Attach documentation (letter from Registrar, class schedule or tuition bill).*	Graduation Date (M/Y)
	Y / N	Y / N	❒		
	Y / N	Y / N	❒		

9. LIFE/DISABILITY

	Request	Refuse/Cancel
11. Life and AD&D	❒	❒
12. Supplemental Life	❒	❒
13. Dependent Life	❒	❒
14. STD	❒	❒
15. LTD	❒	❒

Current Earnings: _____
❒ Annual
❒ Monthly
❒ Weekly

Life Insurance Amount: _____

10. BENEFICIARY INFORMATION

To the EMPLOYER: This is the only record of an employee's beneficiary designation. Please retain a copy and submit it at the time of request for death benefits. This form should also be used for any changes in beneficiary designation. Please record the appropriate date.

Beneficiary Name: Last, First, Middle Initial (See examples of beneficiary designations in the Life Insurance Instructions section on page 1)

Relationship of Beneficiary: Date:

IMPORTANT! - The employee's and employer's signatures are required before submitting this application. Please turn to page 4 to complete the Authorization section. CBIA and Aetna reserve the right to delay or deny enrollment if information or required signatures are missing from the enrollment form.

ACKNOWLEDGEMENT

The following information should be read carefully before completing and signing the enrollment/change form:

The employee certifies by his/her signature that he/she understands that misstatements, material misrepresentations or omissions may result in his/her coverage being void as of its effective date with no benefits payable. The employee requests the group coverage for which he/she is eligible and authorizes deductions from his/her earnings to serve as payment for any required contributions. The employee authorizes any physician, other health professional, all hospitals and other health care institutions to provide by the Plan selected, Plan contracted physicians and any independent claim administrators, consulting health professionals and utilization review organizations with whom the Plan has contracted, information concerning health care advice, treatments or supplies provided to the employee's dependents and/or the employee (including those involving mental illness) relating to coverage under the Plan. This information will be used for coordinating patient care, evaluating and administering claims for benefits, and for fulfilling obligations imposed on the Plan by federal or state law. The Plan may provide the named employer with any benefit calculation used in the payment of these claims for the purpose of reviewing the experience and operation of the policy or contract. The employee's signature on the enrollment form affirms that all information and statements provided on the form are full, complete and true to the best of the employee's knowledge. If the employee has refused coverage, the enrollment form certifies that he/she does not wish to be insured for the Group Coverages. The employee understands that if he/she wishes to apply for coverage at a future date, he/she will then have to comply with the rules governing late applications. The employee also understands that coverage may be refused if he/she wishes to apply for coverage at any time other than open enrollment. If either the employee or the employee's spouse currently has coverage with another insurance carrier and at a future date loses that coverage, those coverages can be obtained under the CBIA/Aetna program.

Note: A written request and documentation of the loss of other coverage and the necessary contribution must be made within 30 days of the other coverage termination. The employee's signature below certifies that he/she has read and agreed to these authorizations.

11. AUTHORIZATION

I have read and agreed to the authorizations and information pertaining to this form (outlined in the Instructions on page 1). My signature below affirms that all information and statements provided on this form are full, complete and true to the best of my knowledge.

❒ I waive all coverages offered by my employer's group insurance plan.

_____ _____
Employee Signature Date

_____ _____
Employer Signature Date

NOTE:
CBIA and Aetna reserve the right to delay or deny enrollment if information or required signatures are missing from the enrollment form.

cbia
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aetna SM

11/2016