aetna®

Enrollment/Change Request

Aetna Life Insurance Company

Effective 1/1/2023

ROOFERS LOCAL #195
(315) 699-1388

7706 MALTLAGE DRIVE
LIVERPOOL, NY 13090

YOU MUST CHOOSE ONE OPTION

UNDER EITHER "PLAN A" OR "PLAN B"

IF YOU DON'T CHOOSE, YOU WILL AUTOMATICALLY BE ENROLLED IN "PLAN A" UNDER THE "SINGLE" OPTION. NO CLAIMS WILL BE PROCESSED WITHOUT A COMPLETED ENROLLMENT FORM

Age 19-26 must submit their own Enrollment Form.
They will be enrolled under the participant's chosen plan.

CHECK ONLY ONE

Plan A: Low Deductible Plans

Deductibles: $500/person - $1,000/family
Office Visit Copay: $15

☐ Single: $975/Month
☐ EE & Spouse: $1,750/Month
☐ Family: $2,042/Month

Plan B: High Deductible Plans

Deductibles: $5,000/person - $10,000/family
Office Visit Copay: $25

☐ Single: $780/Month
☐ EE & Spouse: $1,400/Month
☐ Family: $1,633/Month

Employer Group Information:
(To Be Completed by Employer)

Employer Name - Full Name of Business or Organization	Control	Suffix	Account	Plan Number
Roofers Local 195 Fund Office	285625	NA	NA	NA

Employer Address (Street, City, State, ZIP Code) - Primary Location of Business or Organization	Group Number (IMO Only)	Customer Code (Optional)
7706 Maltage Drive , Liverpool, NY 13090	863887-10-007	NA

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

Instructions: *Refer to the instructions on the back before completing this form. You, the employee, 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.*

Enrollment - *Check one.*
☐ New Enrollee/Subscriber ☐ Rehire/Reinstatement
Effective Date: 1 / 1 / 23
Date of Rehire/Reinstatement: / /
Date of Hire: XX / XX / XXXX

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 Admin.
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	Home Address	Apt. No. City, State	ZIP Code
☐ Active ☐ Retired			

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	
Not Applicable - Forms available through Fund Office	Not Applicable	Not Applicable	☐ Annually $ NA ☐ Weekly $	☐ Insurance Amount $ ☐ Supplemental Life $ NA ☐ AD&D Amount $

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

Check One:

☐ Aetna Choice® POS II
☐ Aetna HealthFund®
☐ Aetna Open Access® Elect Choice
☐ Aetna Open Access® Managed Choice
☐ Elect Choice® EPO
☐ Managed Choice® POS
☑ Open Choice® PPO
☐ Traditional Choice®
☐ Aexcel®
☐ Aexcel® Plus
☐ Other ____

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

(A)dd (C)hange (R)emove	Name (First, Middle Initial, Last) (Explain difference in last names in Special Remarks.)	Relation. Code	Sex M F	Birthdate MM DD YYYY	Social Security Number (If dependent has no SSN, write "None".)	Prior Insur. Plan	Other Medical Coverage	Other Rx Drug Coverage	Handi-capped	Primary Medical Office ID Number	Current Patient
		Self	☐ ☐	/ /		Yes * ☐	Yes * ☐	Yes * ☐	Yes ☐	NA	Yes ☐
			☐ ☐	/ /		☐	☐	☐	☐	NA	☐
			☐ ☐	/ /		☐	☐	☐	☐	NA	☐
			☐ ☐	/ /		☐	☐	☐	☐	NA	☐
			☐ ☐	/ /		☐	☐	☐	☐	NA	☐

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

Code	Other
	NA
	NA
	NA
	NA
	NA

Using the KEY below, please identify the Race/Ethnicity code for each individual.

KEY:
01 - White
02 - African American or Black
03 - Hispanic or Latino
04 - Asian
05 - Other (Provide race/ethnicity in "Other" column at left)

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 and 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 and your **Member Identification Number.**

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

Special Remarks

E. Employee Signature ☐ *By checking this box you agree to use Aetna's 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 please visit Aetna Navigator®.*

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 the reverse side of this Enrollment/Change Request form.

Employee Signature - *Required*	E-Mail Address	Date	Primary Language Spoken
X		/ /	

Instructions

Employer - Complete the **Employer Group Information** at the top of the form. **Employee - Complete Sections A - E.**

Section A - Type of Activity:

- Check box(es) indicating reason(s) for submitting this Enrollment/Change Request.
- Provide Effective Date(s) and 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: Select only an option 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 name(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
  - 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 and ending effective dates, name and policy number of insurance carrier, HMO or other source and your **Member Identification Number** 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 and ending effective dates, name and policy number of insurance carrier, HMO or other source and your **Member Identification Number** 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" and 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 "DocFind®", Aetna's online provider directory at "www.aetna.com".
- If you are a current patient, please check the "Yes" box under Current Patient.
- *Optional* - Using the KEY provided, please enter the Race/Ethnicity code for each individual. If your Race/Ethnicity is "Other," print the Race/Ethnicity for each individual in the space provided.

Section E - Employee Signature:

- Complete this section for all new enrollments or coverage changes.
- Employee must sign and date the Enrollment/Change Request in order for it to be processed.
- By checking the box on the reverse side you agree to use Aetna Navigator, Aetna's member self-service website, for all future printed materials and understand you may choose to receive paper documents in the future.

Conditions of Enrollment

Applicant Acknowledgments and Agreements

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

1. I acknowledge, that by enrolling in an Aetna plan, coverage is underwritten or administered by Aetna Life Insurance Company (referred to as "Aetna").
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 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 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 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 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 the term of the coverage and so long thereafter as allowed by law. I understand that I am 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 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 insurance act, which is a crime and subjects such person to criminal and civil penalties.

Attention Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company, who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant, for the purpose of defrauding or attempting to defraud the policyholder or claimant, with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Attention Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.