

***Employees:** Return this completed form to your employer.
***Employers:** Log in at ppienroll.com to update member enrollment; please retain this completed form for your records. Try *Express Terminations* and *Express Compensation* to easily enter multiple updates.

695 Bergen Ave. Corp dba Play & Learn
ENROLLMENT/CHANGE FORM
PPI Employer No. 024700



Section 1 – Plan Options

Please complete the following (Employer Use Only):

REQUIRED: Employee Annual Salary \$ _____

Payroll/Benefit Deduction Frequency: _____

☐ Guardian PPO Dental

☐ Avesis Advantage Plus Vision Plan

☒ Aetna Life & AD&D

☒ Aetna LTD

Section 2 – Type of Activity

***Employer must complete both of the following if enrolling or changing coverage:**

***Date of Hire or Rehire:**

____ - ____ - ____

***Effective Date of Coverage:**

____ - ____ - ____

1. ENROLL FOR COVERAGE (List all enrollees in Section 3):

☐ New/Rehire

☐ Open Enrollment

☐ Part-time to Full-time status

☐ Loss of other coverage (HIPAA Cert from prior carrier required)

Date of Loss of Coverage: _____

2. CHANGES TO COVERAGE

A. Add Dependents (List Deps in Section 3):

☐ Birth/Adoption

☐ Marriage

☐ Other (**specify**): _____

Date of Event: _____

PLEASE NOTE THE FOLLOWING:

Provider Changes after your initial election must be reported directly to the insurance carrier.

B. Other Changes (Specify on form)

☐ Open Enrollment Plan Change

☐ Name Change

☐ Address Change

☐ Beneficiary Change

3. REMOVE COVERAGE

A. Cancel Dependents (List Deps in Section 3):

☐ Loss of Student Status

☐ Divorce/Separation

☐ Gained Other Coverage

☐ Death

☐ Other (**specify**): _____

Date of Loss: _____

B. Term Employee Coverage

☐ Reduced Hours

☐ Gained Other Coverage

☐ Retirement

☐ Other (**specify**): _____

Date of Loss: _____

Section 3 – Individuals Covered (A=Add C=Change R=Remove)

EMPLOYEE:

Last Name		First Name		SS#		____		____		____		____		____			
Home Address										City		State		Zip		____	
Date of Birth		____/____/____		Gender: ☐ M ☐ F		Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other											
Job Title:																	
Phone: (____) ____-____										Email: _____							
Dental: ☐ A ☐ C ☐ R				Vision: ☐ A ☐ C ☐ R													

SPOUSE (SSN Required if Electing Dental):

Last Name		First Name		SS#		____		____		____		____		____	
Date of Birth		____/____/____		Gender: ☐ M ☐ F											
Dental: ☐ A ☐ C ☐ R				Vision: ☐ A ☐ C ☐ R											

CHILD (SSN Required if Electing Dental):

Last Name		First Name		SS#		____		____		____		____		____	
Date of Birth		____/____/____		Gender: ☐ M ☐ F											
Full-time Student? ☐ No ☐ Yes (Complete Section 4)				Handicapped Child? ☐ No ☐ Yes (Separate form may need to be completed)											
Dental: ☐ A ☐ C ☐ R				Vision: ☐ A ☐ C ☐ R											

CHILD (SSN Required if Electing Dental):

Last Name		First Name		SS#		____		____		____		____		____	
Date of Birth		____/____/____		Gender: ☐ M ☐ F											
Full-time Student? ☐ No ☐ Yes (Complete Section 4)				Handicapped Child? ☐ No ☐ Yes (Separate form may need to be completed)											
Dental: ☐ A ☐ C ☐ R				Vision: ☐ A ☐ C ☐ R											

CHILD (SSN Required if Electing Dental):

Last Name		First Name		SS#		____		____		____		____		____	
Date of Birth		____/____/____		Gender: ☐ M ☐ F											
Full-time Student? ☐ No ☐ Yes (Complete Section 4)				Handicapped Child? ☐ No ☐ Yes (Separate form may need to be completed)											
Dental: ☐ A ☐ C ☐ R				Vision: ☐ A ☐ C ☐ R											

Please use a separate sheet of paper for additional dependents.

Please continue on the reverse side

Section 4 – Student Status Information for Non-Medical Plans

Generally, dependents over the age of 18 must be full-time students to be eligible for non-medical coverage. Please list below all full-time students from Section 3. Include the name of the school and the student's expected date of graduation. Use a separate sheet of paper for additional students.

Dependent Name: _____
Name of School: _____
Expected Graduation Date: _____

Dependent Name: _____
Name of School: _____
Expected Graduation Date: _____

Section 5 – Life Insurance Beneficiary Designation

Primary Beneficiary Name(s)	SS#	Relationship	Date of Birth	% of Benefit (whole #'s)
Contingent (if primary deceased)				

Section 6 – Waiver of Coverage (Complete and sign ONLY if waiving coverage(s) for yourself and/or your dependents)

I hereby certify that I have been given an opportunity to enroll for Group Health Insurance benefits offered by my employer and have decided **NOT** to enroll in the following coverage(s):

☐ Dental

☐ Dependent Dental

☐ Vision

☐ Dependent Vision

I understand that if I delay enrolling more than 31 days after the date I could first become insured, the Dental benefits for myself and my dependents may be limited for a period time as determined by the plan rules.

Employee's Signature

Date

Section 7 – Employee Signature

I represent that all the information supplied in this application is true and complete. I have personally designated the beneficiaries shown on this form (if applicable) and hereby request group insurance for myself and for my dependents listed on this form for selected coverages noted in Section 1. I hereby authorize my employer or successor to make deductions from my earnings of the required contributions, if any, to apply toward the insurance costs for the insurance provided for in the policy of group insurance issued to my employer.

I understand that the effective date of insurance for myself or for any of my dependents is subject to my being actively at work on that date and that the effective date of insurance for any of my dependents is also subject to the dependent health condition requirements of the Plan. Further, I understand that any insurance subject to evidence of good health or medical information will not become effective until the carrier gives its written consent.

I understand that, in the event I fail to sign this form within 31 days of the effective date of eligibility or that for any reason the carrier does not receive notice of the Enrollment/Change Request within a reasonable time following the event, my eligibility and my dependent's eligibility may be affected.

Misrepresentations: Any person who knowingly and with intent to defraud 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.

Employee's Signature

Date

Section 8 – Employer Verification

Employer's Signature	Title	Date
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IMPORTANT: Employees: Please review this form for accuracy and completeness before signing it and giving it to your employer; incomplete forms will cause a delay in processing. **Employers:** Please use your employees' completed forms to update member enrollment at www.ppienroll.com. If you need access to or assistance with AutoEnroll, please contact the PPI Service Team at clientservices@ppibenefits.com or (888) 674-0046.