



Enrollment/Change Request

Aetna*

This form must be completed in full or it will be returned to you resulting in a delay in processing. You, the employee, are solely responsible for its accuracy & completeness.

Employer Name The Board of Trustess of St. Petersburg College	Customer Code (Optional)
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A. Type of Activity - Employee Completes Sections A through H. Please Print Clearly.

Check box(es) indicating reason(s) for submitting this Enrollment/Change Request.

Enrollment - Check one. <input type="checkbox"/> New Enrollee/Subscriber Effective Date: ____/____/____ Date of Hire: ____/____/____ <input type="checkbox"/> Rehire/Reinstatement Date of Rehire/Reinstatement: ____/____/____	Change - Check all that apply. <input type="checkbox"/> Name <input type="checkbox"/> Plan <input type="checkbox"/> Other - Explain in Section G, Special Remarks. <input type="checkbox"/> Control / Suffix / Account: Date of Event: ____/____/____ Reason: _____	Terminate - Check one. <input type="checkbox"/> Terminate All Current Coverages <input type="checkbox"/> Terminate Selected Coverages Effective Date: ____/____/____ Reason: _____	Continuation of Coverage, i.e., COBRA, State - Not all continuation options are available. Contact Employer for available options. Coverage For: <input type="checkbox"/> Employee <input type="checkbox"/> Dependents Length of Continuation (months): <input type="checkbox"/> 18 <input type="checkbox"/> 36 <input type="checkbox"/> Other ____ <input type="checkbox"/> 29 - Attach disability determination from the Social Security Administration Date of Loss of Coverage: ____/____/____ Date of Qualifying Event: ____/____/____
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B. Plan Options Check box(es) indicating the benefits you are electing or changing at this time.

Available Plan Options	Control # (Group #)	Suffix (Location)	Account (Class Code)	Plan #	Plan # (Copay)	Description
<input type="checkbox"/> Aetna Choice™ POS II	727557					
<input type="checkbox"/> Open Access Aetna Select SM	727557					
<input type="checkbox"/> Dental PPO	727557					

C. Employee Information - Please Print Clearly.

Social Security Number /Social Insurance Number		Last Name, First Name, M.I.			
Employee Status <input type="checkbox"/> Active <input type="checkbox"/> Retired		Occupation / Title		What is your primary language?	
Home Telephone () ()		Alternate Telephone - Optional () ()		Work Telephone () () Ext.	
Home Address		Apt. No. City, State		ZIP Code	
Employer Name				Work State	
Work Address		City, State		ZIP Code	

D. Individuals Covered - Part 1 (Also complete Part 2) Provide details for additional children in Section G, Special Remarks. Attach proof if full-time college student.

Family Code	Last Name, First Name, M.I. <small>Full names must be provided for all individuals for whom you are adding, changing or removing coverage.</small>	Relationship to * Employee	Sex M / F	Birthdate			Social Security Number / Social Insurance Number	Coverages: Indicate action being taken at this time. (A)dd/New (C)hange (R)emove/Terminate (W)aive ***								
				MM	DD	YYYY		Medical	Dental	Basic Life	Supplemental Life	Basic Life AD&PL/AD&D	Suppl Life AD&PL/AD&D	STD	LTD	
EMP		Self		/	/											
SP				/	/										N/A	N/A
01				/	/										N/A	N/A
02				/	/										N/A	N/A
03				/	/										N/A	N/A

** Document relationship in Section G, Special Remarks, if other than spouse or biological/adopted child.

*** Applies to available plan options only.

D. Individuals Covered - Part 2 NOTE: Use the same sequence of individuals listed in Part 1 when completing Part 2.

Family Code	Late Entrant	Prior Coverage	Other Medical Coverage	Other Rx Drug Coverage	Other Dental Coverage	Handi-capped	Student	Primary Medical Office ID Number	Current Patient	Dentist Office ID Number (If applicable)	Current Patient	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
EMP	Yes <input type="checkbox"/>	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	N/A <input type="checkbox"/>	N/A <input type="checkbox"/>	Yes <input type="checkbox"/>		Yes <input type="checkbox"/>		
SP	<input type="checkbox"/>	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
01	<input type="checkbox"/>	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
02	<input type="checkbox"/>	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
03	<input type="checkbox"/>	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		

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)

If "Yes" to Other Medical, Rx Drug and/or Dental Coverage(s) above, provide name & policy number of insurance carrier, HMO, or other source.

Does any dependent listed in above live at a different address than the Employee? If "Yes," who and what address?
 Yes No Explain the circumstances.

If any dependent's last name differs from yours, explain the circumstances. Is your Spouse Employed? Yes No If "Yes," provide name and address of spouse's employer.

E. Life (Including AD&PL and AD&D) - Continued on Page 3

Requested Employee Coverage	Requested Dependent Coverage	Control #	Suffix	Account

Change

Plan

Increase/Decrease Benefit Amount*

Other *

Effective Date (MM/DD/YYYY)

____ / ____ / ____

*Provide explanation in Section G, Special Remarks.

Employee Coverage Amounts - Based on the requirements of your Plan, you may have to submit evidence of good health.

Employee Annual Earnings \$	Basic Life Amount \$	Supplemental Life Amount \$	Basic AD&PL/AD&D Amount \$	Supplemental AD&PL/AD&D Amount \$
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Dependent Coverage Amounts (if applicable)

Dependent Name	Basic Dependent Amount	Supplemental Dependent Amount	Basic Dependent AD&PL/AD&D Amount	Supplemental Dependent AD&PL/AD&D Amount
SP	\$	\$	\$	\$
01	\$	\$	\$	\$
02	\$	\$	\$	\$
03	\$	\$	\$	\$

Tobacco Use: Have you used tobacco products (Cigarettes, cigars, pipe, chewing tobacco) within the past 12 months? **Employee:** Yes No **Spouse:** Yes No (if applicable)

E. Life (Including AD&PL and AD&D) - Continued from Page 2

Employee Beneficiary Designation - If additional beneficiaries, use Section G, Special Remarks. Dependent coverage Beneficiary is always the Employee.			
Full Beneficiary Name (First, Middle, Last)	Social Security Number / Social Insurance Number of Beneficiary	Relationship to Employee	% of Benefit
<input checked="" type="checkbox"/> Primary			
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			

F. Short and Long Term Disability - Employee Only

Based on the requirements of your Plan, you may be required to submit evidence of good health.		Control #	Suffix	Account
<input type="checkbox"/> Short Term Disability - Check appropriate box below. <input type="checkbox"/> Increase Coverage <input type="checkbox"/> Decrease Coverage _____ Indicate New Plan Name or Change in Coverage		<input type="checkbox"/> Long Term Disability - Check appropriate box below. <input type="checkbox"/> Increase Coverage <input type="checkbox"/> Decrease Coverage _____ Indicate New Plan Name or Change in Coverage		

G. Special Remarks - Use this space to provide clarification and/or additional information as requested in Sections A through F. Please Print Clearly.

H. Conditions of Enrollment - Continued on Page 4 *Signature Required*

On behalf of myself and the dependents listed on Page 2, I agree to or with the following:

- * I acknowledge that by enrolling in the following plans, coverage is underwritten or administered by the following entities (collectively referred to as "Aetna"):
 - HMO: Aetna Health Inc.
 - QPOS/Aetna Choice POS/USAccess: Aetna Health Inc., Corporate Health Insurance Company, Aetna Health Insurance Company of New York, and/or Aetna Health Insurance Company of Connecticut
 - Aetna DMO, Aetna Dental PPO, Dental EPP, Aetna DentalFund and Aetna Indemnity Dental: Aetna Life Insurance Company
 - Life, disability, and all other health coverages: Aetna Life Insurance Company
- 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. **For life and disability coverages:** I understand that the effective date of insurance for myself or for any of my dependents, if applicable, 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 benefit plan. 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 Aetna does not receive notice of the Enrollment/Change Request within a reasonable time following the event, my and my dependents' eligibility, if applicable, may be affected. Further, I understand that any insurance subject to evidence of good health or medical information will not become effective until Aetna gives its written consent.
4. 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 and substance abuse. 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.
5. The plan documents (Schedule of Benefits, Group Agreement, Certificate of Coverage, Group Policy, Group Insurance Certificate, Booklet) 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.
6. I understand and agree that with the exception of Aetna Rx Home Delivery, all participating providers (including all participating primary care dentists) 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.
7. I understand and agree that, with certain exceptions described in the plan documents, certain medical plans only provide coverage for referred benefits, and that, in order to be covered, services 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 referral from a participating primary care physician.

I certify that all information supplied in this form is true and complete. I have read and agree to the Conditions of Enrollment on this Enrollment/Change Request form.

Misrepresentation: Any person who knowingly and with the intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Employee Signature (Required) X Date (MM/DD/YYYY) / /

Employee E-mail Address _____