



Dental Enrollment/Change Request

Aetna Life Insurance Company *

Employer Group Information: (To Be Completed by Employer)	Employer Name - Full Name of Business or Organization	Control	Suffix	Account	Plan Number
	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.

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. <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"/> Add Spouse <input type="checkbox"/> Add Dependent Child <input type="checkbox"/> Name Change <input type="checkbox"/> Other <input type="checkbox"/> Control/Suffix/Acct/Plan	Date of Event: / / Reason: _____	Remove or Terminate - Check all that apply. <input type="checkbox"/> Remove Spouse <input type="checkbox"/> Remove Dependent Child <input type="checkbox"/> Employee Withdrawal/Termination <input type="checkbox"/> Cancel Coverage	Effective Date: / / Reason: _____	Continuation of Coverage, i.e., COBRA, State - Not all 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 Admin. Date of Loss of Coverage: / / Date of Qualifying Event: / /
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B. Employee Information

Social Security Number	Last Name, First Name, M.I.	Primary Language Spoken
Employee Home Address Number, Street, Apt	Telephone Numbers Home () Work ()	Employee Status <input type="checkbox"/> Active <input type="checkbox"/> Retired
City, State	ZIP Code	

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

Check One:

<input type="checkbox"/> Indemnity Dental	<input type="checkbox"/> Dental EPP	<input type="checkbox"/> FOC/Indemnity
<input type="checkbox"/> DentalFund/HealthFund	<input type="checkbox"/> DMO*/Advantage/Basic	<input type="checkbox"/> FOC/PPO
<input type="checkbox"/> Dental PPO		<input type="checkbox"/> FOC/DMO

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. * Provide details for "Yes" responses below. Check this box if you are refusing coverage for your dependents.

(Add/Change/Remove)	Name (First, Middle Initial, Last) (Explain difference in last names in Special Remarks.)	Relation Code	Sex		Birthdate MM DD YYYY	Social Security Number (If dependent has no SSN, write "None")	Late Entrant	Prior Insur. Plan	Other Dental Coverage	Currently Covered by Medicare	Handi-capped	Student	Primary Dentist Office ID Number	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.)		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)
			M	F											Code	Other	
		Self	<input type="checkbox"/>	<input type="checkbox"/>	/ /		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	Yes		<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>	/ /		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	Yes		<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>	/ /		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	Yes		<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>	/ /		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	Yes		<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>	/ /		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	Yes		<input type="checkbox"/>			

1. If "Yes" to Prior Insurance Plan above, provide effective dates, name & policy number of insurance carrier, dental plan 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. If "Yes" to Other Dental Coverage and/or Currently Covered by Medicare above, provide effective dates, name & policy number of insurance carrier, dental plan or other source and your Member Identification Number.	Special Remarks

E. Employee Signature By checking this box you agree to use Aetna Navigator, Aetna's member self-service website, for all future printed materials.

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. I understand that in the event I fail to sign this form within 31 days after the above transaction request or that for any reason Aetna does not receive notice of the above transaction request within a reasonable time following the event, my and my dependents' eligibility may be affected.	Employee Signature - Required X
Date: / /	E-Mail Address