aetna®

Dental Enrollment/Change Request

Aetna Life Insurance Company
Aetna Dental of California Inc.
Aetna Health of California Inc.

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Aetna Dental of California Inc.
6303 Owensmouth Avenue
Suite 900
Woodland Hills, CA 91367

Aetna Health of California Inc.
6303 Owensmouth Avenue
Suite 900
Woodland Hills, CA 91367

TO COMPLY WITH CALIFORNIA LAW WHEREVER THE TERM "SPOUSE" APPEARS IT SHALL BE CONSTRUED TO INCLUDE A DOMESTIC PARTNER.

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

Employer Group Information (To Be Completed by Employer)	**Control**	**Suffix**	**Account**	**Plan Number**

Employer Name – Full Name of Business or Organization

Employer Address (Street, City, State, ZIP Code) – Primary Location of Business or Organization

A. Type of Activity – Employee Completes Sections A – D. *Please Print Clearly.*

Enrollment – *Check one.*
- ☐ New Enrollee/Subscriber

Effective Date: _____

Date of Hire: _____

- ☐ Rehire/Reinstatement

Date of Rehire/ Reinstatement _____

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, Cal-COBRA - *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 Administration

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

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

Check One:

- ☐ Indemnity Dental
- ☐ Dental PPO
- ☐ Advantage/Basic/Preventive
- ☐ FOC/PPO
- ☐ DentalFund/HealthFund
- ☐ DMO®
- ☐ FOC/Indemnity
- ☐ FOC/DMO®

DMO is not an available option if you reside in any of the following states: AK, AL, AR, GU, LA, ME, MS, MT, ND, NE, NH, PR, SC, VI, VT, WV and WY.

D. Individuals Covered - *List individuals for whom you are enrolling or adding/changing/removing coverage.*

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

☐ **Employer Group allows dependent coverage to age 26** ☐ **Not applicable**

(A)dd **(C)**hange ____ **(R)**emove	**1. Employee Name** - Last, First, M.I.	Relation Code **Self**	Sex (M/F)	**Birthdate** (MM/DD/YYYY)

Social Security Number	Late Entrant **Yes** ☐	Prior Insurance Plan **Yes*** ☐	Other Dental Coverage **Yes*** ☐	Currently Covered by Medicare **Yes*** ☐	Physically or Mentally Disabled **N/A**	Primary Dentist Office ID Number	Current Patient **Yes** ☐

Continued on Page 2

D. Individuals Covered – (continued) ***List individuals for whom you are enrolling or adding/changing/removing coverage.***

**** Provide details for "Yes*" responses below.*** Attach sheet to list additional children.

(A)dd (C)hange ____ (R)emove	**2. Spouse Name** - Last, First, M.I. (Explain difference in last name in Special Remarks.)	Relation Code	Sex (M/F)	**Birthdate** (MM/DD/YYYY)

Social Security Number (if dependent has no SSN, write "None")	Late Entrant **Yes** ☐	Prior Insurance Plan **Yes*** ☐	Other Dental Coverage **Yes*** ☐	Currently Covered by Medicare **Yes*** ☐	Physically or Mentally Disabled **Yes** ☐	Primary Dentist Office ID Number	Current Patient **Yes** ☐

(A)dd (C)hange ____ (R)emove	**3. Child Name** - Last, First, M.I. (Explain difference in last name in Special Remarks.)	Relation Code	Sex (M/F)	**Birthdate** (MM/DD/YYYY)

Social Security Number (if dependent has no SSN, write "None")	Late Entrant **Yes** ☐	Prior Insurance Plan **Yes*** ☐	Other Dental Coverage **Yes*** ☐	Currently Covered by Medicare **Yes*** ☐	Physically or Mentally Disabled **Yes** ☐	Primary Dentist Office ID Number	Current Patient **Yes** ☐

(A)dd (C)hange ____ (R)emove	**4. Child Name** - Last, First, M.I. (Explain difference in last name in Special Remarks.)	Relation Code	Sex (M/F)	**Birthdate** (MM/DD/YYYY)

Social Security Number (if dependent has no SSN, write "None")	Late Entrant **Yes** ☐	Prior Insurance Plan **Yes*** ☐	Other Dental Coverage **Yes*** ☐	Currently Covered by Medicare **Yes*** ☐	Physically or Mentally Disabled **Yes** ☐	Primary Dentist Office ID Number	Current Patient **Yes** ☐

(A)dd (C)hange ____ (R)emove	**5. Child Name** - Last, First, M.I. (Explain difference in last name in Special Remarks.)	Relation Code	Sex (M/F)	**Birthdate** (MM/DD/YYYY)

Social Security Number (if dependent has no SSN, write "None")	Late Entrant **Yes** ☐	Prior Insurance Plan **Yes*** ☐	Other Dental Coverage **Yes*** ☐	Currently Covered by Medicare **Yes*** ☐	Physically or Mentally Disabled **Yes** ☐	Primary Dentist Office ID Number	Current Patient **Yes** ☐

(A)dd (C)hange ____ (R)emove	**6. Child Name** - Last, First, M.I. (Explain difference in last name in Special Remarks.)	Relation Code	Sex (M/F)	**Birthdate** (MM/DD/YYYY)

Social Security Number (if dependent has no SSN, write "None")	Late Entrant **Yes** ☐	Prior Insurance Plan **Yes*** ☐	Other Dental Coverage **Yes*** ☐	Currently Covered by Medicare **Yes*** ☐	Physically or Mentally Disabled **Yes** ☐	Primary Dentist Office ID Number	Current Patient **Yes** ☐

1. If "Yes" to **Prior Insurance Plan** and/or **Other Dental Coverage** above, provide effective dates, name & policy number of insurance carrier, HMO, or other source & your **Member Identification Number**.

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

Special Remarks

Conditions of Enrollment

NOTICE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Applicant Acknowledgments and Agreements

On behalf of myself and the dependents listed on Pages 1 and 2, I agree to or with the following:

1. I acknowledge that by enrolling in the following plans, coverage is underwritten or administered by the following entities (collectively referred to as "Aetna"):
   - Aetna Dental PPO, Aetna HealthFund/Aetna DentalFund and Aetna Indemnity Dental: Aetna Life Insurance Company.
   - Aetna Dental DMO®: Aetna Dental of California Inc.
   - Aetna Dental Advantage, Preventive and Basic: Aetna Health of California Inc.
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. The plan documents (Schedule of Benefits, Group Agreement, Evidence of Coverage, amendments, riders or endorsements) will determine the rights and responsibilities of the employee and dependents and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
4. 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.
5. I understand and agree that, with certain exceptions described in the plan documents, DMO® plans only provide coverage for referred benefits, and that, in order to be covered, services must be performed either by a participating primary care dentist, or by the participating specialist, hospital, pharmacy, physician, or other provider as authorized by a referral from a participating primary care dentist.

Misrepresentation

Attention California Residents: For your protection, California law requires notice of the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison

Employee Signature

IT IS IMPORTANT THAT YOU READ AND UNDERSTAND THE FOLLOWING BEFORE YOU SIGN.

To the best of my knowledge, I represent that all information supplied in this form is true and complete. I have read and agree to the Conditions of Enrollment and Misrepresentation on this California Employee Enrollment/Change Request form.

Applicable to DMO and HMO Enrollees only: **NOTICE OF BINDING ARBITRATION: ANY DISPUTE ARISING FROM OR RELATED TO HEALTH PLAN MEMBERSHIP MAY BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION, AND NOT BY A LAWSUIT OR RESORT TO COURT PROCESS EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. THE AGREEMENT TO ARBITRATE INCLUDES, BUT IS NOT LIMITED TO, DISPUTES INVOLVING ALLEGED PROFESSIONAL LIABILITY OR MEDICAL MALPRACTICE, THAT IS, WHETHER ANY MEDICAL SERVICES COVERED BY THIS AGREEMENT WERE UNNECESSARY OR WERE UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED. THE HEALTH PLAN AGREEMENT ALSO LIMITS CERTAIN REMEDIES AND MAY LIMIT THE AWARD OF PUNITIVE DAMAGES. SEE THE EVIDENCE OF COVERAGE FOR FURTHER INFORMATION.**

I understand that I am giving up the constitutional right to have disputes decided in a court of law before a jury, and instead am accepting the use of binding arbitration. This means that members will not be able to try their case in court. I further understand that the Health Plan agreement contains limitations on certain remedies and that there may be certain limitations to the recovery of punitive damages.

Employee Signature *- Required* **X**	***Date (Month/Day/Year)***	***Employee E-mail Address (optional)***	***Primary Language Spoken***

Employer Verification (To Be Completed by Employer)

Employer Signature *- Required* **X**	***Title***	***Date (Month/Day/Year)***

Instructions

Employer

- Complete the **Employer Group Information** at the top of Page 1.
- Complete the **Employer Verification** below the Employee signature on Page 3. Employer must sign & date the Enrollment/Change Request for new enrollments or coverage changes to be processed.

Employee – Complete Sections A – D. Additional dependent and/or other information may be provided on a separate sheet. All attachments must be signed & dated.

Section A – Type of Activity:

- Check box(es) indicating reason(s) for submitting this Enrollment/Change Request.
- Provide Effective Date(s) & Date of Event(s) where requested.

Section B – Employee Information:

- Complete **all** information in order for your Enrollment/Change Request to be processed.

Section C – Plan Options: Your selection must be 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 names(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, & Social Security Number for each individual.
  - *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 Dental Coverage**, check the "Yes" box(es) and provide beginning & ending effective dates, name & policy number of insurance carrier, HMO or other source & your **Member Identification Number** for the insurance plan in the space provided in Number 1.
- If a dependent is Physically or Mentally Disabled & financially dependent, check "Yes" & provide proof of physical or mental disabled status from the attending physician.
- Primary Dental Office ID Number: Locate the office ID number for the primary care dentist 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.

.**Conditions of Enrollment/Misrepresentation – Employee Signature:** Employee must sign & date the Enrollment/Change Request for new enrollments or coverage changes to be processed.

DMHC Written Notice of Availability of Language Assistance

HMO and DMO-based plans - **IMPORTANT:** Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-877-287-0117.

Planes basados en DMO y HMO - **IMPORTANTE:** ¿Puede leer esta carta? En caso de no poder leerla, le brindamos nuestra ayuda. También puede obtener esta carta escrita en su idioma. Para obtener ayuda gratuita, por favor llame de inmediato al 1-877-287-0117.

DOI Written Notice of Availability of Language Assistance

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-877-287-0117. For more help call the CA Dept. of Insurance at 1-800-927-4357 English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-877-287-0117. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

免費語言服務。您可獲得口譯員服務，用中文把文件唸給您聽。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打 1-877-287-0117 與我們聯絡。欲取得其他協助，請致電1-800-927-4357 與加州保險部聯絡。Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch và được người khác đọc giúp các tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-877-287-0117 . Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese.

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-877-287-0117번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-877-287-0117. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-877-287-0117 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-877-287-0117. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または1-877-287-0117までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Japanese

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره 1-877-287-0117 تماس بگیرید. برای دریافت کمک بیشتر، به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تلفن کنید. Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-877-287-0117 'ਤ ਸਾਨ ਫ਼ਨ ਕਰੋ। ਵਧੇਰ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

េសវាកម្មភាសាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-877-287-0117 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា

តាមលេខ 1-800-927-4357 Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-877-287-0117 . للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357.Arabic

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-877-287-0117. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

CDI Notice of Language Assistance-Trad