Enrollment/Change Request

Aetna Life Insurance Company

Aetna US Healthcare

Check One: ☐ Elect Choice® EPO ☐ HMO ☐ Managed Choice® POS ☐ Traditional Choice® ☐ Open Choice® PPO ☐ Other _____

A. Transaction Information

EFFECTIVE DATE (MM/DD/YYYY)

1. Enrollment (Check One)

- ☐ New Enrollee — Hire Date ___/___/___ (MM DD YR)
- ☐ Rehired/Reinstatement — Date ___/___/___ (MM DD YR)
- ☐ Return to Work — Date ___/___/___ (MM DD YR)

2. Change — From / To

- ☐ Social Security Number ___-___-___ / ___-___-___
- ☐ Control/Suffix/Acct (B.2.) _____ / _____
- ☐ Stop Continuation of Health Coverage (i.e., COBRA)
- ☐ Other _____

3. Termination

- ☐ Terminating Employment - Reason _____
- ☐ Cancelling Coverage - Reason _____
- ☐ Continue Employee Health Coverage (i.e., COBRA)
- ☐ Continue Dependent Health Coverage (i.e., COBRA)

B. Employer Information

1. Employer Name - Full Name of Business or Organization	2. Control No.	Suffix	Account	3. Plan Number	4. Group Number (HMO Only)	5. SFO
Orthodox Health Plan	658408	10				076

6. Employer Address (Street, City, State, ZIP Code) - Primary Location of Business or Organization	7. Claim Office Code	8. Customer Code (Optional)	9. Network ID

C. Employee Information - Please Print All Information

1. Employee Social Security Number	2. Employee Name (Last, First, Middle Initial)	3. Employee Home Address
___-___-___		Number, Street, Apt.

4. Employee Status	5. Sex	6. Home Telephone Number	7. Work Telephone Number	City	State	ZIP Code
☐ Active ☐ Retired		(___) ___-___	(___) ___-___			

8. Beneficiary Designation - **Full Beneficiary Name** (First, Middle, Last) If more than one beneficiary, use Special Remarks.	Social Security Number of Beneficiary	Relationship to Employee	9. Earnings	
	___-___-___		☐ Annually $ _____ ☐ Weekly $ _____	☐ Insurance Amount $ _____ ☐ Supplemental Life $ _____ ☐ AD&D Amount $ _____

D. Individuals Covered (List individuals for whom you are electing/changing coverage.)

☐ Check this box if you are refusing coverage for your dependents.

(A)dd/New (C)hange (R)emove	Relation. Code	Name (First, Middle Initial, Last) (Explain difference in last names in Special Remarks)	Social Security Number (If dependent has no SSN, write "None")	Birthdate MM / DD / YYYY	Dependent Address (If different than employee)	Prior Insur. Plan	Other Health Coverage	Currently Covered by Medicare	Handi-capped	Student Age 19 or Older	Primary Care Provider ID # / Primary Care Provider Name	Prev. Seen
	Self		___-___-___	/ /	Not Applicable	Yes* ☐	Yes* ☐	Yes ☐	Yes* N/A	Yes* N/A	ID # / Name	Yes ☐
			___-___-___	/ /		☐	☐	☐	☐	☐	ID # / Name	☐
			___-___-___	/ /		☐	☐	☐	☐	☐	ID # / Name	☐
			___-___-___	/ /		☐	☐	☐	☐	☐	ID # / Name	☐
			___-___-___	/ /		☐	☐	☐	☐	☐	ID # / Name	☐

Special Remarks

E. Acknowledgments - Signatures Required

Employee's E-mail Address:

I have read and agree to the terms of the authorization on the back 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 X _____ Date _____ **Employer Signature** X _____ Date _____