



Dental Enrollment/Change Request

Aetna Life Insurance Company

Employer Group Information: (To Be Completed by Employer)

Employer Name - Full Name of Business or Organization _____ Plan Number _____

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

Control _____ Suffix _____

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.

Change - Check all that apply

Add Spouse Add Spouse Add Spouse Add Spouse

Add Dependent Child Add Dependent Child Add Dependent Child Add Dependent Child

Name Change Name Change Name Change Name Change

Other Other Other Other

Control/Suffix/Account/Plan Control/Suffix/Account/Plan Control/Suffix/Account/Plan Control/Suffix/Account/Plan

Remove or Terminate - Check all that apply

Remove Spouse Remove Spouse Remove Spouse Remove Spouse

Remove Dependent Remove Dependent Remove Dependent Remove Dependent

Child Child Child Child

Employee Withdrawal/Termination Employee Withdrawal/Termination Employee Withdrawal/Termination Employee Withdrawal/Termination

Cancel Coverage Cancel Coverage Cancel Coverage Cancel Coverage

Continuation of Coverage, i.e., COBRA

Coverage For: Employee Dependents

Length of Continuation (months): 18 36 Other _____

29 - Attach disability determination from the Social Security Admin.

Date of Loss of Coverage: _____ / _____ / _____ Date of Qualifying Event: _____ / _____ / _____

B. Employee Information

Social Security Number _____ Last Name, First Name, M.I. _____

Employee Home Address _____ Telephone Numbers _____

Number, Street, Apt _____ Home () _____

City, State _____ Work () _____

ZIP Code _____

Employee Status: Active Retired

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

Check One:

Indemnity Dental Dental EPP FOC/Indemnity

Dental Fund/Health Fund DMO/Advantage/Basic FOC/PPO

Dental PPO 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.

First Name (Last, Middle Initial, Last) (Explain difference in last names in Special Remarks.)	Sex M F	Birthdate MM DD YYYY	Social Security Number (If dependent has no SSN, write "None")	Late Enrollment		Prior Plan		Other Insurance		Hand-Student	Primary Dentist Office ID Number	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.)
				Yes	No	Yes	No	Yes	No			
Self	<input type="checkbox"/>	/ /		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	/ /		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	/ /		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	<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)

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

Special Remarks

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.

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.

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 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 _____ Date _____

Employee Signature - Required _____ Date _____

E-Mail Address _____