Aetna Voluntary Plans

(formerly Aetna Affordable Health Choices®)
Enrollment/Change Request

Landrum Staffing Services, Inc.
800769

Insurance plans are underwritten by Aetna Life Insurance Company (referred to as "Aetna") and administered by Aetna or Strategic Resource Company (SRC, an Aetna company).

Instructions: Read and fill out the Enrollment/Change Request (all pages). Make a copy for yourself. Give the original to your employer.
IF YOU ARE NOT CHANGING YOUR EXISTING COVERAGE, YOU DO NOT NEED TO COMPLETE THIS ENROLLMENT/CHANGE REQUEST.

INFORMATION ABOUT YOU Complete all information.

Print your name (first, middle initial, last) | Social Security Number | Date of birth (MM/DD/YYYY)

Home address | Apartment number | City | State | Zip code

Home phone ( ) | Work phone ( ) | Email address | Sex ☐ Male ☐ Female | Primary language spoken (Idioma principal)

ACTION YOU WANT TO TAKE Check the box next to the action you want to take.

I am not currently enrolled and I want to…	☐ **Enroll** in the coverage choices selected below. ☐ **Decline** this opportunity to participate.
I am currently enrolled and I want to…	☐ **Make changes to** my current coverage choices (add, increase, drop, decrease) as selected below. All of my other coverage choices will remain the same as previously elected. *(If outside of an open enrollment, see "Making Changes Outside of an Open Enrollment.")* ☐ **Update** my personal and/or my dependent information. ☐ **Drop all** of my current coverage choices.

Your payroll deductions will be taken after taxes are taken.

YOUR COVERAGE CHOICES Check(☑) the box for the level of coverage you want.

Coverage type	Coverage level	Weekly cost
Medical	☐ No Medical	
	☐ Yourself only	$ 35.69
	☐ Yourself plus one	$ 90.17
	☐ Yourself and family	$129.35
	Group limited benefit medical coverage is not available if you live and work in New Hampshire.	

YOUR AUTHORIZATION You must sign and date this Enrollment/Change Request for all new enrollments or coverage changes.

I represent that all information supplied in this Enrollment/Change Request 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.
Misrepresentation: *Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or any application containing any false, incomplete or misleading information is guilty of a felony of the third degree.*

Your signature | Today's date (MM/DD/YYYY)

EMPLOYER GROUP INFORMATION This section is to be completed by your employer.

Employee ID | Hire date (MM/DD/YYYY) | Pay type | Total deduction ($) | **Effective date** (MM/DD/YYYY)

Location or site code | Authorized signature | Title | Today's date (MM/DD/YYYY)

INFORMATION ABOUT YOU Repeat your name and Social Security number here.

Print your name (first, middle initial, last) | Social Security Number

INFORMATION ABOUT YOUR DEPENDENTS List the dependents for whom you are adding/changing/removing coverage.

If you have more dependents, write down their information on a separate sheet and attach it to this Enrollment/Change Request.

☐ Add
☐ Change
☐ Remove

Print dependent's name (first, middle initial, last) | Social Security Number

Sex
☐ Male / ☐ Female

Date of birth

Relationship:
☐ Spouse ☐ Child ☐ Other (Specify): ____________________

Address (if different than yours) | City | State | Zip code

☐ Add
☐ Change
☐ Remove

Print dependent's name (first, middle initial, last) | Social Security Number

Sex
☐ Male / ☐ Female

Date of birth

Relationship:
☐ Spouse ☐ Child ☐ Other (Specify): ____________________

Address (if different than yours) | City | State | Zip code

☐ Add
☐ Change
☐ Remove

Print dependent's name (first, middle initial, last) | Social Security Number

Sex
☐ Male / ☐ Female

Date of birth

Relationship:
☐ Spouse ☐ Child ☐ Other (Specify): ____________________

Address (if different than yours) | City | State | Zip code

MAKING CHANGES OUTSIDE OF AN OPEN ENROLLMENT Please read below to see if you are able to make changes to your coverage.

You can add to or increase your coverage during the plan year only if you have a **Qualifying Life Event (QLE)**. If your deductions are taken after taxes, you may drop or decrease coverage at any time. QLEs fall under one of these two categories:

Loss of Other Coverage (LOC): If you previously declined health coverage because you or your dependents were already covered under another health plan and you or your dependents have lost that other coverage, you may be able to enroll yourself and your dependents. If you had a recent LOC, go to the list on the right and check the box next to your LOC and supply the date of the LOC.

Family Status Change (FSC): Whether you are currently enrolled or previously declined coverage, you may be able to add or increase coverage when you experience certain FSC events. If you had a recent FSC, go to the list on the right and check the box next to your FSC and supply the date of the FSC.

Next, complete the rest of this Enrollment/Change Request. When finished, make a copy and submit it to your employer with your documentation attached. You must submit this Enrollment/Change Request, together with documentation, to your employer within 30 days of the LOC/FSC.

Loss of Other Coverage (LOC):
☐ Divorce, legal separation or death
☐ Termination of employment of a dependent
☐ Reduction of a dependent's hours
☐ Termination of your or your dependents' COBRA rights
☐ Loss of employer's contribution to spouse's coverage
☐ Dependent child losing eligibility as a dependent
☐ Other loss of coverage

Family Status Change (FSC):
☐ Divorce, legal separation or death
☐ Marriage
☐ Birth or adoption of a dependent
☐ Other

Date of LOC or FSC (mm/dd/yyyy)

CONDITIONS OF ENROLLMENT Applicant acknowledgments and agreements

On behalf of myself and the dependents listed on this Enrollment/Change Request, I agree to or with the following:

1. I acknowledge that by enrolling in an Aetna plan coverage is underwritten by Aetna Life Insurance Company (referred to as "Aetna") 151 Farmington Avenue, Hartford, CT 06156 and administered by Aetna or Strategic Resource Company (SRC, an Aetna company), 221 Dawson Road, Columbia, SC 29223.
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. 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, 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.
4. The plan documents 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.
5. 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.
6. **Attention Florida Residents:** Any person who knowingly and with 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.