Coverage is provided by the following entities: Aetna Health of California Inc. for HMO, Aetna Dental of California Inc. for Dental (DMO only) and Aetna Life Insurance Company for all other coverage.

Small Group Employee Change of Coverage Application – CA

(For Existing Enrollments Only)

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

Instructions:

Before requesting a different plan, please read the Aetna brochure describing the plan you are thinking of choosing.

Be sure you are acquainted with the benefits, co-payments, annual deductibles and the limitations and exclusions of the plan you choose. The plan you choose must be part of your employer's Small Group benefit coverage.

1. **You, the employee, must complete this application.** You are solely responsible for its accuracy and completeness.
2. All questions must be answered in full and all signatures and dates must be included where noted, otherwise, the application may be returned to you, resulting in a delay in processing and possibly a delay in the effective date of coverage.
3. **Type or print clearly using blue or black ink.**

1. Choice of Coverage – *Please change my coverage to:*

Control/Group No.	Suffix	Account	Plan No.	Class Code	Control/Group No.	Suffix	Account	Plan No.	Control/Group No.	Suffix	Account	Plan No.

1. Medical - Check one.

HMO: ☐ 10 ☐ 15 ☐ 20 ☐ 30 ☐ 40
☐ HRA 750 ☐ HRA 1500
☐ Deductible 1000

Aetna Value Network℠ HMO:
☐ 10 ☐ 20 ☐ 30 ☐ 40

Vitalidad Mexico HMO: ☐ 5 ☐ 10

EPO: ☐ EPO 80

MC: ☐ 250 90/70 ☐ 250 80/60
☐ 500 80/60 ☐ 750 80/50/50
☐ 1000 80/50/50 ☐ 1000 70/50
☐ 2000 80/50/50 ☐ 2500 75/50
☐ 10,000 100/50
☐ Basic
☐ HRA HDHP 3000 80/50
☐ HSA HDHP 2500 80/50
☐ HSA HDHP 3000 100/50
☐ HSA HDHP 3300 80/50

PPO: ☐ 500 90/70 ☐ 750 80/60

☐ **Aetna Indemnity**

☐ **Out-of-State**

2. Dental - Check one. (if applicable)

Standard Plans:

☐ **1** - DMO® Access
☐ **2** - DMO® Plus (Plan 58)
☐ **3** - Freedom-of-Choice Basic:
☐ DMO® or ☐ PPO
☐ **4** - Freedom-of-Choice Plus:
☐ DMO® or ☐ PPO
☐ **5** - PPO 1000 Active
☐ **6** - PPO 1500
☐ **7** - PPO 1500 Active
☐ **8** - PPO 2000
☐ Out-of-State PPO

Voluntary Plans:

☐ Option **V1** - DMO® Access
☐ Option **V2** - DMO® Plus (Plan 58)
☐ Option **V3** - PPO 1000 Active
☐ Option **V4** - PPO 1500
☐ Option **V5** - PPO 1500 Active
☐ Out-of-State PPO

Before today, were you covered under this employer's dental plan? ☐ Yes ☐ No

3. Life

☐ Basic Life/AD&D Ultra™
☐ Optional Dependent Life

Beneficiary Designation -
Full Name (First, Middle, Last)

Beneficiary Social Security Number

Relationship to Employee

2. Subscriber Information – *Please complete portion ONLY if a recent change.*

Last Name, First Name, M.I.			Social Security or ID Number
Address (P.O. Box not acceptable)	Apt. No.	City, State	ZIP Code
Home Telephone	Work Telephone	No. of Dependents Including Spouse	Spouse's Social Security or ID Number
Job Title	Employer Name		No. of Hours Worked Per Week

3. Subscriber/Family Information – ***List individuals for whom you are enrolling or adding/changing/removing coverage. Insert additional sheets if necessary. If spouse's last name is different from yours, is he/she a domestic partner?*** ☐ Yes ☐ No

1. Self Name (Last, First, M.I.)				Sex (M/F)	Social Security Number		
Birthdate (MM/DD/YYYY)	Height (ft, in)	Weight (lbs)	Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated	PCP Provider Office ID Number	Current Patient **Yes** ☐	Dental Office ID Number (if applicable)	Current Patient **Yes** ☐

2. Spouse Name (Last, First, M.I.)				Sex (M/F)	Social Security Number	Relationship ☐ Spouse ☐ Other ____________	
Birthdate (MM/DD/YYYY)	Height (ft, in)	Weight (lbs)	Status ☐ Different Last Name	PCP Provider Office ID Number	Current Patient **Yes** ☐	Dental Office ID Number (if applicable)	Current Patient **Yes** ☐

3. Child Name (Last, First, M.I.)				Sex (M/F)	Social Security Number	Relationship ☐ Child ☐ Stepchild ☐ Other ____________	
Birthdate (MM/DD/YYYY)	Height (ft, in)	Weight (lbs)	Status ☐ Different Last Name ☐ Lives at another address ☐ Full-Time Student (19+) ☐ Disabled (19+)	PCP Provider Office ID Number	Current Patient **Yes** ☐	Dental Office ID Number (if applicable)	Current Patient **Yes** ☐

4. Child Name (Last, First, M.I.)				Sex (M/F)	Social Security Number	Relationship ☐ Child ☐ Stepchild ☐ Other ____________	
Birthdate (MM/DD/YYYY)	Height (ft, in)	Weight (lbs)	Status ☐ Different Last Name ☐ Lives at another address ☐ Full-Time Student (19+) ☐ Disabled (19+)	PCP Provider Office ID Number	Current Patient **Yes** ☐	Dental Office ID Number (if applicable)	Current Patient **Yes** ☐

4. Health History of Members Currently Enrolled - Provide the required medical information if any enrolled family member has been hospitalized, seen a physician or other health care provider or taken prescription medication within the last 6 months.

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

Name of Individual	**Condition**	**Medication Prescribed**	**Dosage**	**Still Taking Medication**
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

5. 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.

6. Authorization

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 Authorization Conditions of Enrollment and Misrepresentation on this **California** Small Group Employee Change of Coverage Application Form.

I understand in the event I fail to sign and return this form within 31 days of my eligibility date or 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.

I am employed by the employer shown on Page 1, and I am working full time at least 30 hours per week for this employer at the regular place of business.

CA HMO ENROLLEES - NOTICE OF BINDING ARBITRATION: ANY DISPUTE ARISING FROM OR RELATED TO HEALTH PLAN MEMBERSHIP WILL 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 agreement contains limitations on certain remedies and that there may be certain limitations to the recovery of punitive damages.

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

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.

Traditional Plans:

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 թարգմանի 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

សេវាកម្មភាសាឥតគិតថ្លៃ ។ 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

©2008 Aetna Life Insurance Company