04.21.2022

STATE OF DELAWARE — DEPARTMENT OF HUMAN RESOURCES — STATEWIDE BENEFITS OFFICE

AETNA — Enrollment/Change Request Form

A. REASON FOR APPLICATION

☐ New coverage
☐ Change coverage
☐ Information change
☐ Waive coverage
Date of event checked: _____

ADD DEPENDENTS DUE TO:
☐ Marriage/Civil Union ☐ Non-voluntary coverage loss
☐ Birth ☐ Other
☐ Adoption/Guardianship
Date of event checked: _____

TERM DEPENDENTS DUE TO:
☐ Divorce ☐ Death
☐ Over age ☐ Other
☐ No longer dependent
Date of event checked: _____

REINSTATE COVERAGE DUE TO:
☐ Administrative error
☐ Other
Date of event checked: _____

B. PERSONAL INFORMATION

Male	Female	Social Security Number	**Employer**	Employer Group Number:

Last Name	First Name	M.I.	Date of Birth (month, day, year)	Home Phone (include area code)	Business Phone (include area code)

Street Address	City	State	Zip Code

C. HEALTH CARE COVERAGE CHOICES

COVERAGE IS FOR: ☐ Employee ☐ Employee & Spouse ☐ Employee & child (ren) ☐ Family
CHOOSE ONE: ☐ Aetna HMO ☐ Aetna CDH Gold ☐ Aetna HMO COBRA ☐ Aetna CDH Gold COBRA

D. ELIGIBLE DEPENDENTS TO BE C OVERED / PRIMARY CARE PHYSICIAN SELECTION

If you select Aetna HMO complete all of the below information. If you Select Aetna CDH Gold you do not need to provide Primary Care Physician information.

If more space is needed to list dependents, please use a separate sheet of paper and attach it to this application.

Name of Your Primary Care Physician	Physician's ID Number	Is this your current physician? ☐YES ☐NO

☐Add ☐Change ☐Remove	Spouse's First Name	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Spouse's Social Security Number	Spouse's Primary Care Physician	Physician's ID Number	Spouse's current physician? ☐Y ☐N
☐Add ☐Change ☐Remove	Dependent's First Name ☐ Fulltime student ☐ Male ☐ Handicapped ☐ Female	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Dependent's Social Security Number	Dependent's Primary Care Physician	Physician's ID Number	Dependent's current physician? ☐Y ☐N
☐Add ☐Change ☐Remove	Dependent's First Name ☐ Fulltime student ☐ Male ☐ Handicapped ☐ Female	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Dependent's Social Security Number	Dependent's Primary Care Physician	Physician's ID Number	Dependent's current physician? ☐Y ☐N

E. OTHER COVERAGE INFORMATION

Anyone covered by other health insurance? ☐I am ☐My spouse ☐My dependent child(ren)	If YES, and the coverage is through an employer, list name of employer below: If covering a spouse you must go online at https://dhr.delaware.gov/benefits/cob/groups.shtml and complete a Coordination of Benefits form.	Name and Location of Other Insurance Company

F. CONDITIONS OF ENROLLMENT – Applicant Acknowle dgments and Agreements

On behalf of myself and dependents listed, 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"):

- HMO
- HMO COBRA
- CDH Gold Plan
- CDH Gold COBRA

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 form, including those involving mental health, substance abuse and HIV/AIDS. 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 copy is as valid as the original. 4) The plan documents (Schedule of Benefits, Group Agreement, Certificate of Coverage, Group Policy, Group Insurance Certificate) will determine the rights and responsibilities or other description of the plan. 5) I understand and agree that, with certain exceptions described in the plan documents, HMO plans only provide coverage for referred benefits, and that, in order to be covered, services must be performed either by a participating primary care physician, or by the participating specialist, hospital, pharmacy, dentist, or other provider as authorized by a referral from a participating primary care physician.

Misrepresentation: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I ELECT to participate in the State Plan and do agree to the above terms.

Signature: _____ Date: _____

I elect **NOT** to participate in the State Plan.

Signature: _____ Date: _____