aetna®

Aetna Vision[SM] Preferred Enrollment/Change Request

Aetna Life Insurance Company

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

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

Instructions: Refer to the instructions on the back before completing this form. You 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.

Employer Group Information (To Be Completed by Employer)	Control	Suffix	Account	Plan Number

Employer Name – Full Name of Business or Organization

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

A. Type of Activity – Employee Completes Sections A – D. *Please Print Clearly.*

Enrollment – *Check one.*
- ☐ New Enrollee/Subscriber

Effective Date: ____/____/____

Date of Hire: ____/____/____

- ☐ Rehire/Reinstatement

Date of Rehire/ Reinstatement ____/____/____

Change – *Check all that apply.*
- ☐ Add Spouse
- ☐ Add Dependent Child
- ☐ Name Change
- ☐ Other _____
- ☐ Control/Suffix/Acct/Plan: _____

Date of Event: ____/____/____

Reason: _____

Remove or Terminate – *Check all that apply.*
- ☐ Remove Spouse
- ☐ Remove Dependent Child
- ☐ Employee Withdrawal/ Termination
- ☐ Cancel Coverage

Effective Date: ____/____/____

Reason: _____

Continuation of Coverage, i.e., COBRA, Cal-COBRA *Not all options are available. Contact Employer for available options.*

Coverage for: ☐ Employee ☐ Dependents

Length of Continuation (months):
- ☐ 18 ☐ 36 ☐ Other _____
- ☐ 29 – Attach disability determination from the Social Security Administration

Date of Loss of Coverage: ____/____/____

Date of Qualifying Event: ____/____/____

Continuation of Coverage Expiration Date: ____/____/____

B. Employee Information

Social Security Number	Last Name, First Name, M.I.			Home Telephone	Work Telephone
Employee Status ☐ Active ☐ Retired	Home Address	Apt. No.	City, State		ZIP Code

Subscriber Primary Language (other than English)
Primer Idioma del suscriptor (que no sea el Ingles)

What is your primary Language? ¿Cuál es su primer idioma?

Subscriber Disability

Do you have a disability which affects your ability to communicate or read?

☐ Yes ☐ No If Yes, please indicate the nature of your disability.

C. Product Information

☒ Aetna Vision[SM] Preferred

Aetna Vision[SM] Preferred may not be available in all states.

D. Individuals Covered - *List individuals for whom you are enrolling or adding/changing/removing coverage.*

☐ Check this box if you are refusing coverage for your dependents. ** Provide details for "Yes*" responses below.*

(A)dd (C)hange (R)emove ____	1. Employee Name - Last, First, M.I.				Relationship Code **Self**	Sex (M/F)
Birthdate (MM/DD/YYYY) / /	Social Security Number	Other Vision Coverage Yes* ☐	Currently Covered by Medicare Yes* ☐	Physically or Mentally Disabled N/A		Student N/A

(A)dd (C)hange (R)emove ____	2. Spouse Name - Last, First, M.I. (Explain difference in last name in Special Remarks.)				Relationship Code	Sex (M/F)
Birthdate (MM/DD/YYYY) / /	Social Security Number (if dependent has no SSN, write "None")	Other Vision Coverage Yes* ☐	Currently Covered by Medicare Yes* ☐	Physically or Mentally Disabled Yes ☐		Student Yes ☐

Continued on Page 2

D. Individuals Covered – (continued) *List individuals for whom you are enrolling or adding/changing/removing coverage.*
** Provide details for "Yes*" responses below.* Attach sheet to list additional children.

(A)dd (C)hange (R)emove ____	3. Child Name - Last, First, M.I. (Explain difference in last name in Special Remarks.)				Relationship Code	Sex (M/F)
Birthdate (MM/DD/YYYY) / /	Social Security Number (if dependent has no SSN, write "None")	Other Vision Coverage Yes* ☐	Currently Covered by Medicare Yes* ☐	Physically or Mentally Disabled Yes ☐		Student Yes ☐

(A)dd (C)hange (R)emove ____	4. Child Name - Last, First, M.I. (Explain difference in last name in Special Remarks.)				Relationship Code	Sex (M/F)
Birthdate (MM/DD/YYYY) / /	Social Security Number (if dependent has no SSN, write "None")	Other Vision Coverage Yes* ☐	Currently Covered by Medicare Yes* ☐	Physically or Mentally Disabled Yes ☐		Student Yes ☐

(A)dd (C)hange (R)emove ____	5. Child Name - Last, First, M.I. (Explain difference in last name in Special Remarks.)				Relationship Code	Sex (M/F)
Birthdate (MM/DD/YYYY) / /	Social Security Number (if dependent has no SSN, write "None")	Other Vision Coverage Yes* ☐	Currently Covered by Medicare Yes* ☐	Physically or Mentally Disabled Yes ☐		Student Yes ☐

(A)dd (C)hange (R)emove ____	6. Child Name - Last, First, M.I. (Explain difference in last name in Special Remarks.)				Relationship Code	Sex (M/F)
Birthdate (MM/DD/YYYY) / /	Social Security Number (if dependent has no SSN, write "None")	Other Vision Coverage Yes* ☐	Currently Covered by Medicare Yes* ☐	Physically or Mentally Disabled Yes ☐		Student Yes ☐

1. If "Yes" to Other Vision Coverage and/or Currently Covered by Medicare above, provide effective dates, name & policy number of insurance carrier, vision plan or other source & your Member Identification Number.

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

Special Remarks:

Conditions of Enrollment

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

Applicant Acknowledgments and Agreements

On behalf of myself and the dependents listed on Pages 1 and 2, I agree to or with the following:

1. I acknowledge that by enrolling in an Aetna Vision℠ Preferred plan, coverage is underwritten by Aetna Life Insurance Company (referred to as "Aetna") and that certain claims adjudication and other administrative services are provided by First American Administrators, Inc. (an affiliate of EyeMed Vision Care, LLC) and/or its affiliates.
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. 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.
4. 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.

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.

☐ *By checking this box you agree to use Aetna Navigator®, Aetna's member self-service website for all future printed materials and understand you may choose to receive paper documents in the future.*

Employee Signature

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 Conditions of Enrollment and Misrepresentation on this Employee Enrollment/Change Request form.

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

Employer Verification (To Be Completed by Employer)

Employer Signature - Required	*Title*	*Date (Month/Day/Year)*
X		/ /

Instructions

Employer

- Complete the Employer Group Information at the top of Page 1.
- Complete the Employer Verification below the Employee signature on Page 3 (above). Employer must sign & date the Enrollment/Change Request for new enrollments or coverage changes to be processed.

Employee – Complete Sections A – D

Additional dependent and/or other information may be provided on a separate sheet. All attachments must be signed and dated.

Section A – Type of Activity:

- Check box(es) indicating reason(s) for submitting this Enrollment/Change Request.
- Provide Effective Date(s) & Date of Event(s) where requested.

Section B – Employee Information:

- Complete all information in order for your Enrollment/Change Request to be processed.

Section C – Product Information

Section D – Individuals Covered:

- Add/Change/Remove – Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the names(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, & Social Security Number for each individual.
  - *Relationship Code* – Use ONLY: H=Husband, W=Wife, S=Son, D=Daughter, Y=Sponsored Male, X=Sponsored Female. If the dependent is NOT your spouse or a biological or legally adopted child, please indicate relationship to employee in Special Remarks.
- If you or your dependent(s) have Other Vision Coverage and/or are Currently Covered by Medicare, check the "Yes" box(es) and provide beginning & ending effective dates, name & policy number of insurance carrier, vision plan or other source & your Member Identification Number for the insurance plan in the space provided in Number 1.
- If a dependent is Physically or Mentally Disabled & financially dependent, check "Yes" & provide proof of disability from the attending physician.
- If a dependent is a Student, check "Yes". Refer to your Summary Coverage for plan definitions. Aetna may request that you provide proof from the educational institution.

Conditions of Enrollment/Misrepresentation – Employee Signature: Employee must sign & date the Enrollment/Change Request for new enrollments or coverage changes to be processed.

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 թարգման 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

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