aetna® Dental Enrollment/Change Request

Aetna Life Insurance Company *

Employer Group Information: (To Be Completed by Employer)

Employer Name - Full Name of Business or Organization: **City of Berwyn Illinois**

Employer Address (Street, City, State, ZIP Code) - Primary Location of Business or Organization: **6700 W 26th St, Berwyn, IL 60402**

Control	Suffix	Account	Plan Number
0876576			

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.*

Enrollment - *Check one.*

☐ New Enrollee/Subscriber ☐ Rehire/Reinstatement

Effective Date / / Date of Rehire/Reinstatement / /

Date of Hire / /

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, State - ***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 Admin.

Date of Loss of Coverage / / Date of Qualifying Event / /

B. Employee Information

Social Security Number | Last Name, First Name, M.I. | Primary Language Spoken

Employee Home Address

Number, Street, Apt

City, State ZIP Code

Telephone Numbers: Home ( ) Work ( )

Employee Status: ☐ Active ☐ Retired

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

Check One:

☐ Indemnity Dental ☐ DentalFund/HealthFund ☐ Dental PPO ☐ Dental EPP ☐ DMO®/Advantage/Basic ☐ FOC/Indemnity ☐ FOC/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.

(A)dd (C)hange (R)emove	Name (First, Middle Initial, Last) (Explain difference in last names in Special Remarks.)	Relation Code	Sex M F	Birthdate MM DD YYYY	Social Security Number (If dependent has no SSN, write "None")	Late Entrant	Prior Insur. Plan	Other Dental Coverage	Currently Covered by Medicare	Handi-capped	Student	Primary Dentist Office ID Number	Current Patient
		Self	☐☐	/ /		Yes ☐	Yes * ☐	Yes * ☐	Yes * ☐	Yes N/A	Yes N/A		Yes ☐
			☐☐	/ /		☐	☐	☐	☐	☐	☐		☐
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			☐☐	/ /		☐	☐	☐	☐	☐	☐		☐

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.)

Code	Other

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)

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**.

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

Special Remarks

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/or 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 - *Required* X

Date / / E-Mail Address