aetna®

Life Enrollment/Change Request

Aetna Life Insurance Company

A. Transaction Information

1. Enrollment

☐ New Employee ☐ Retiree

☐ Rehire/Reinstatement

Effective Date (MM/DD/YYYY)

Date of Hire (MM/DD/YYYY)

Requested Employee Coverage

☐ Basic Life

☐ AD&PL/AD&D

☐ Supplemental Life

☐ Supplemental AD&PL/AD&D

Requested Dependent Coverage

☐ Basic Dependent Life

☐ Basic Dependent AD&PL/AD&D

☐ Supplemental Dependent Life

☐ Supplemental Dependent AD&PL/AD&D

2. Termination (Cancel)

☐ Employee *

* Employee must be enrolled for dependent(s) to have coverage.

Effective Date (MM/DD/YYYY)

3. Change (*Provide explanation in Section D, Special Remarks.)

☐ Add Dependent(s) ☐ Plan Change

☐ Remove Dependent(s) ☐ Other*

☐ Increase/Decrease Benefit Amount*

Effective Date (MM/DD/YYYY)

B. Employer Information

1. Employer Name - Full Name of Business or Organization	2. Control No.	Suffix	Account	3. Plan Number	4. SFO
The Episcopal Church in Connecticut	**0603226**				**076**

5. Employer Address (Street, City, State, ZIP Code) - Primary Location of Business or Organization	6. Claim Office Code	7. Customer Code (Optional)
290 Pratt St, Meriden, CT 06450	**174**	

C. Employee Information - Please Print all Information

1. **Employee Social Security Number**	2. Employee Name (Last, First, M.I.)	3. Birthdate (MM/DD/**YYYY**)	4. Sex	5. Telephone Numbers
- -		/ /		Home ( ) - Work ( ) -

6. Employee Home Address (Number, Street, **Apt. No.,** City, State, ZIP Code)	7. Employee Annual Earnings	8. Occupation/Title
	$	

9. Employee Coverage Amounts (Based on the requirements of your Plan, you may have to submit evidence of good health.)

Basic Life Amount	Supplemental Life Amount	Basic AD&PL/AD&D Amount	Supplemental AD&PL/AD&D Amount
$	$	$	$

10. Beneficiary Designation - If more than one beneficiary, use Special Remarks. Dependent coverage Beneficiary is always the Employee.

Full Beneficiary Name (First, Middle, Last)	Social Security Number of Beneficiary	Relationship to Employee
	- -	

D. Covered Dependents (Complete only if Dependent Coverage is offered under your Plan.)

☐ Check this box if you are refusing coverage for your dependents.

(A)dd/New (C)hange (R)emove	**Dependent Name** (First, Middle Initial, Last)	**Social Security Number** (If dependent has no SSN, write "None")	**Relation. Code**	**Birthdate** MM / DD / YYYY	**Student Age 19 or Older** Yes No	**Basic Dependent Amount**	**Supplemental Dependent Amount**	**Basic Dependent AD&PL/AD&D Amount**	**Supplemental Dependent AD&PL/AD&D Amount**
		- -		/ /	☐ ☐	$	$	$	$
		- -		/ /	☐ ☐	$	$	$	$
		- -		/ /	☐ ☐	$	$	$	$
		- -		/ /	☐ ☐	$	$	$	$

Special Remarks

E. Certification - Signatures Required

Employee's E-mail Address:

My signature below signifies my agreement with the statements and authorization under **Certification and Authorization** on the back of this form.

1. Employee Signatures *(Required)*	Date	**2. Employer Signature** *(Required)*	Date
X		**X**	

Instructions - Instructions are provided only for those fields which are not self-explanatory or for which you may need additional information.

A. Transaction Information

*Make sure you complete the **Effective Date** in Section **A** - Transaction Information.*

*Make sure you read Section **E**. **Sign name and date.***

To Enroll

- Complete ***Effective Date*** and ***Date of Hire*** in Section **A** - Transaction Information.
- Check the box(es) applicable to the benefit(s) you wish to enroll for in Section **A** - Transaction Information, Number **1**.
- Complete **all** blank fields in Section **B** - Employer Information and Section **C** - Employee Information.
- Complete Section **D** - Covered Dependents for all dependents for whom you are electing coverage. Complete **ALL** items for each individual listed.
- Make sure you read Section **E** - Certification. Sign name and date.

To Terminate (Cancel)

- Complete ***Effective Date*** in Section **A** - Transaction Information, Number **2** and check appropriate box.
- Complete all blank fields in Section **B** - Employer Information *and* Section **C** - Employee Information.
- Make sure you read Section **E** - Certification. Sign name and date.

To Change

- Complete ***Effective Date*** in Section **A** - Transaction Information, Number **3** and check appropriate box(es).
- Complete blank fields in Section **B** - Employer Information (if applicable).
- Complete Section **C -** Employee Information.
- Indicate change(s) in appropriate Section(s) (**B, C, D**) and ***circle***.
- Make sure you read Section **E** - Certification. Sign name and date.

B. Employer Information

The Servicing Field Office (B4) and Claim Office Code (B6) are assigned by Aetna.

B2. **Control, Suffix and Account** - If this information is not preprinted, provide the complete Control, Suffix and Account numbers.

B3. **Plan Number** - If this information is not preprinted, refer to the Plan Sheet to determine the correct Plan Number.

B7. **Customer Code (Optional)** - Provide an identifying Customer Code for the employee only if you had elected to provide this information.

C. Employee Information

To be completed by the Enrollee.

C3. **Birthdate -** Date of birth should include **four digit year of birth.**

C9. **Employee Coverage Amounts** - Consult your Benefits Administrator to identify which earnings/insurance amounts need to be reported. Complete the appropriate box and enter the rounded dollar amount.

C10. **Beneficiary Designation** - *Full Beneficiary Name (First, Middle and Last)*, Social Security Number and relationship of the person to whom benefits will be paid in the event of your death.

D. Covered Dependents

To be completed by Enrollee.

List only those individuals for whom you are electing/ changing coverage and complete ALL items for each individual listed.

- **Add/Change/Remove** - Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- **Name** - This **must** be completed for all individuals for whom you are electing or changing coverage. Please complete **ALL** items in Section **D** for each individual listed. Attach another form if you are requesting coverage for additional dependents.
- **Relationship Code** - Use **ONLY**: H=Husband, W=Wife, N=Divorced Spouse, S=Son, D=Daughter, Y=Sponsored Male, X=Sponsored Female. **If the dependent is NOT a biological or legally adopted child, please indicate relationship to employee in Special Remarks.**
- **Birthdate** - Date of birth should include **four digit year of birth**.
- **Student Age 19 or Older** - Defined as: Unmarried dependent child age 19 or older (refer to your Summary of Coverage), regularly attends school and depends solely on the enrollee for support. Member Services may request that you provide proof from the educational institution.
- **Insurance Amounts** - Consult your Benefits Administrator to identify which insurance amounts need to be reported. Complete the appropriate box(es).

E. Certification

Signatures Required

- Read the information contained above the space provided for your signature in Section **E** and the information on the back of the form.
- **Sign and date the form.**

Certification	I certify that all information on this form is true and complete to the best of my knowledge and belief. I understand that this insurance is subject to all of the terms of the Plan of Insurance contained in the group policy and summarized in the announcement material provided me and the certificate issued to me. I understand that the effective date of insurance for myself or for any of my dependents is subject to my being actively at work on that date and that the effective date of insurance for any of my dependents is also subject to the dependent health condition requirements of the Plan. Further, I understand that any insurance subject to evidence of good health or medical information will not become effective until Aetna gives its written consent. I understand that, in the event I fail to sign this form within 31 days of the effective date of eligibility or that for any reason Aetna does not receive notice of the Enrollment/Change Request within a reasonable time following the event, my and my dependents' eligibility may be affected. I request my employer to arrange for the issuance of Group Life Coverage for which I am or may become eligible and authorize deductions of the required contributions from my earnings.
Misrepresentation	**Misrepresentations:** Any person who knowingly and with intent to defraud 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. **Attention California Residents:** For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison, and substantial civil penalties. Many other states have similar laws. **Attention Colorado Residents: An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.** **Attention Florida and Virginia Residents:** Any person who knowingly and with intent to 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. **Attention Pennsylvania Residents:** Any person who knowingly and with intent to defraud 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.