



Dental Enrollment/Change Request

Example

Employer Group Information: (To Be Completed by Employer)

Employer Name - Full Name of Business or Organization: _____

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

Control: _____ Suffix: _____ Account: _____ Plan Number: _____

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/Shift/Account Plan

Remove or Terminate - Check all that apply:
 Remove Spouse
 Remove Dependent Child
 Employee Withdrawal/Termination
 Cancel Coverage

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: 1A3-45-6789 Last Name, First Name, MI: Doe, John

Employee Home Address: 111 Mesa Telephone Numbers: Home 972, 555-1212

Number, Street, Apt: _____ Work (): _____

City, State: Glenn Heights, TX ZIP Code: 75154

Employee Status: Active Retired

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

Check One:
 Indemnity Dental
 Dental-Fund/Health-Fund
 Dental PPO
 Dental POS
 DMO/Advantage/Basis
 FOC/Indemnity
 FOC/PPO
 FOC/DMO

Choose FOC/PPO DOE

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.

Age (Change or Renewal)	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")	Date Entered MM/DD/YY	Prior Insurance Plan	Other Insurance Coverage	Currently Covered by Medicare	Handicapped (checked)	Student	Primary Office ID Number - Optional	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.)	Other	Race/Ethnicity code for each individual. 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)
A	John Doe	Self	M	01/01/1970	1A3-45-6789	Yes	Yes	Yes	Yes	Yes	Yes	61			

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 employer? 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 requests and understand you may choose to receive paper documents in the future.

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: [Signature] Date: 1/1/12

Print Name: John Doe Email Address: doe@yahood.net

What is your primary language? English
 (Check one) English Spanish Other _____