Enrollment/Change Request
Aetna U.S. Healthcare®**

This application is for use by:
Aetna U.S. Healthcare of North Texas Inc. ~ *Dallas/Fort Worth area*
Aetna U.S. Healthcare Inc. ~ *Austin/Corpus Christi/El Paso/Houston/San Antonio area*

Please mail all applications to:
Aetna U.S. Healthcare**
ATTN: AUSHC Eligibility
P.O. Box 4307
Houston, TX 77210-4307

1. Plan Option (Check One) ***Please read instructions on reverse side before completing this form. Print clearly.***

☐ HMO _____ (Please Indicate Plan Name) ☐ USAccess™ _____ (Please Indicate Plan Name) ☐ MCII/QPOS® _____ (Please Indicate Plan Name)

Primary Co-pay: ☐ $0 ☐ $2 ☐ $5 ☐ $10 ☐ $15 ☐ Other ___ Individual Deductible Amount: *(Complete for QPOS Plans Only)* ☐ $100 ☐ $200 ☐ $300 ☐ $400 ☐ $500 ☐ $750 ☐ $1,000 ☐ Other _____

Group Number | Group Name

2. Employee Information

Last Name, First Name, M.I. | Social Security Number
Home Address | Apartment Number
City, State | Zip Code | Home Telephone ( )
Employer Name | Work Telephone ( )
Work Address | Zip Code | Date of Hire

6. 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? _____

7. 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.

3. Type of Activity

☐ New Subscriber Effective Date _____
☐ Add/Remove Spouse* Reason _____ Date of Event _____
☐ Add/Remove a Dependent Child* Reason _____ Date of Event _____
☐ Name Change From _____ To _____ Date of Event _____
☐ Change Plan To _____ Date of Event _____
☐ Add/Change Primary Office*
☐ Add/Change OB/GYN* (Read Notice on Back)
☐ Add/Change Primary Dentist*
☐ Withdrawal/Termination (Complete Section 10 Below)

* ***Complete Sections 4 & 5 Below***

4.	No.	Add	Remove	Last Name, First Name, M.I.	Sex M F	Date of Birth MM DD YYYY	Social Security Number
Employee	a.	☐	☐		☐ ☐	/ /	
Spouse	b.	☐	☐		☐ ☐	/ /	
Children	c.	☐	☐		☐ ☐	/ /	
*Attach sheet to list additional children *Attach proof if full-time college student	d.	☐	☐		☐ ☐	/ /	
	e.	☐	☐		☐ ☐	/ /	
	f.	☐	☐		☐ ☐	/ /	

5.	Change	Primary Office Number	Current Patient	OB/GYN Office Number (Not required) (Read Notice on Back)	Dentist Office Number (If applicable)	Current Patient
a.	☐		☐			☐
b.	☐		☐			☐
c.	☐		☐			☐
d.	☐		☐			☐
e.	☐		☐			☐
f.	☐		☐			☐

8. Other Insurance

Is your Spouse Employed? ☐ Yes ☐ No
If Yes, please give name and address of spouse's employer.

Does your spouse have health Insurance? ☐ Yes ☐ No
If Yes, please give name and policy number of insurance carrier or other HMO.
If Yes, who is covered by this policy? ☐ Yourself ☐ Yourself/Spouse ☐ Spouse Only ☐ Entire Family

9. Dependent Information

Do any of the dependents listed in Section 4 live at another address? ☐ Yes ☐ No
If Yes, who and at what address?
Explain the circumstances.
If any dependent's last name is different from yours, explain the circumstances.

11. Employee Signature

If you have any questions concerning the benefits and services that are provided by or excluded under this Agreement, please contact a Member Services representative at 1-800-323-9930 before signing this form.

Subscriber _____

Date _____

E-mail Address _____

*Employee copy may be used as a temporary ID card for 30 days from the effective date if authorized by employer. Coverage must be verified with Aetna U.S. Healthcare** prior to visiting a specialist or admission to a hospital.*

10. Withdrawal From Plan

☐ No Longer in Group Date of Withdrawal _____
Note: For COBRA information - See your employer
☐ Individual Conversion - Bill me at Home (Not all benefits are convertible, including but not limited to prescription drug and dental.)
☐ I Decline Nongroup Coverage

12. Employer Verification

Signature | Title | Date

AETNA U.S. HEALTHCARE

**Also doing business as Aetna U.S. Healthcare Inc.; Aetna U.S. Healthcare of North Texas, Inc.

Enrollment/Change Request Instructions

To Enroll: Complete all sections, except Section 10

To Make Changes: ***For all changes*** - complete Sections 2, 3, 11 and 12. Depending on the **Type of Activity** box(es) selected, complete the corresponding applicable sections. A Withdrawal/Termination also requires completion of Section 10.

Attention Female Members: Your choice of a PCP affects your choice of an OB/GYN. In selecting your PCP, remember that your PCP's network affects your choice of an OB/GYN. You have the right to receive services from an OB/GYN without first obtaining a referral from your PCP. However, the OB/GYN from whom you receive services must belong to the same network as your PCP. This is another reason to make certain that our PCP's network includes the specialists - particularly the OB/GYN - and hospitals that you prefer. You are not required to designate an OB/GYN. You may elect to receive your OB/GYN services from your PCP.

Section 1	Check one Plan Option box, indicate Plan Option Name (where applicable) and check one Primary Co-pay and/or Individual Deductible Amount (if applicable).
Section 2	Complete **all** information in order for your application to be processed.
Section 3	Check box(es) indicating reason(s) for submitting form. Provide Effective Date/Date of Event and Reason (where requested).
Section 4	Print your full name along with the name(s) of your dependent(s), if applicable. Indicate Sex, Date of Birth, and Social Security Number for each individual listed. If a dependent is a full-time college student, you **must** attach a current course schedule or a letter from the school confirming full-time student status (as determined by the school). To indicate whether you are Adding or Removing self and/or dependents, check the appropriate Add or Remove boxes.
Section 5	From the appropriate provider directory, locate the office number for the primary care physician and/or dentist (if applicable). Indicate office number selection(s) on form. Check the change block **only** if you are a current member and are changing providers.
Sections 6, 7, 8 & 9	Complete these sections for all new enrollments or coverage changes (if applicable).
Section 10	Complete this section **only** if Withdrawing/Terminating from the plan.
Sections 11 & 12	Complete these sections for all new enrollments or coverage changes. Employee and Employer **must** sign and date the application in order for it to be processed.

Conditions of Enrollment

Applicant Acknowledgments and Agreements

On behalf of myself and the dependents listed on the reverse side, I agree to or with the following:

1. Enrollment of yourself and of the listed dependents into the plan shall be effective on acceptance by Aetna U.S. Healthcare**.
2. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. Your employer is hereby authorized to withhold premium payments from your wages as appropriate.
3. As a condition of coverage, you understand and agree that (with the exception of emergency procedures and certain direct access services as defined in the plan documents) all services, in order to be covered by the Aetna U.S. Healthcare**, 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 prior referral from a participating physician***.
4. You agree to make copayments, as provided for in your plan documents, directly to providers of health care.
5. Aetna U.S. Healthcare** (including its affiliates and agents, collectively "Aetna U.S. Healthcare") and participating network providers require access to member medical information for a number of purposes, including claims payment and fraud prevention; preventive health, early detection and disease management programs; coordination of patient care; quality improvement/management/assessment; utilization review and management; fulfilling state and federal requirements; HEDIS and similar data collection and reporting; accreditation by the National Committee for Quality Assurance and other accreditation organizations; and statistical research. Accordingly, you authorize the sharing of member medical information about yourself and your listed dependents between Aetna U.S. Healthcare** and any hospital, physician, or other health care provider or health delivery system as Aetna U.S. Healthcare** and such participating network providers may require. Please be assured that it is Aetna U.S. Healthcare's** policy to protect the confidential medical information to the full extent required by the law. I know that I, or an individual entitled to act on my behalf, am entitled to receive a copy of this authorization upon request and agree that a photocopy is as valid as the original.
6. 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 HMO plan.
7. You understand that this coverage will remain in effect until your employer's next open-enrollment period regardless of the continued availability of a particular primary care physician or other health care provider.
8. You acknowledge that Aetna U.S. Healthcare's** participating providers, including all participating primary care physicians, are independent contractors and are neither agents nor employees of Aetna U.S. Healthcare**.

Your enrollment in Aetna U.S. Healthcare and accessing of your benefits signifies your agreement to these conditions, which are subject to change.

*** *Some services may require prior authorization from Aetna U.S. Healthcare.*

Misrepresentation

9. 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.

**Also doing business as Aetna U.S. Healthcare Inc.; Aetna U.S. Healthcare of North Texas, Inc.