



Aetna Voluntary Plans
 (formerly Aetna Affordable Health Choices®)
Enrollment/Change Request

AccruePartners
800457

Insurance plans are underwritten by Aetna Life Insurance Company (referred to as "Aetna") and administered by Aetna or Strategic Resource Company (SRC, an Aetna company).

Instructions: Read and fill out the Enrollment/Change Request (all pages). Make a copy for yourself. Give the original to your employer.
IF YOU ARE NOT CHANGING YOUR EXISTING COVERAGE, YOU DO NOT NEED TO COMPLETE THIS ENROLLMENT/CHANGE REQUEST.

INFORMATION ABOUT YOU Complete all information.

Print your name (first, middle initial, last) _____ Social Security Number _____ Date of birth (MM/DD/YYYY) _____

Home address _____ Apartment number _____ City _____ State _____ Zip code _____

Home phone () _____ Work phone () _____ Email address _____ Sex Male Female Primary language spoken (Idioma principal) _____

ACTION YOU WANT TO TAKE Check the box next to the action you want to take.

I am not currently enrolled and I want to...

Enroll in the coverage choices selected below.
 Decline this opportunity to participate.

I am currently enrolled and I want to...

Make changes to my current coverage choices (add, increase, drop, decrease) as selected below. All of my other coverage choices will remain the same as previously elected. (If outside of an open enrollment, see "Making Changes Outside of an Open Enrollment.")
 Update my personal and/or my dependent and/or beneficiary information.
 Drop all of my current coverage choices.

Your payroll deductions will be taken after taxes are taken.

YOUR COVERAGE CHOICES Check (☑) the box for the level of coverage you want.

Coverage type	Coverage level	Weekly cost	Semimonthly cost
Medical	<input type="checkbox"/> No Medical		
	<input type="checkbox"/> Yourself only.....	\$ 28.13.....	\$ 60.95
	<input type="checkbox"/> Yourself plus one	\$ 70.96.....	\$ 153.75
	<input type="checkbox"/> Yourself and family.....	\$ 100.81.....	\$ 218.42
<i>Group limited benefit medical coverage is not available if you live and work in New Hampshire.</i>			
Hospital Indemnity	<input type="checkbox"/> No Hospital Indemnity		
	<input type="checkbox"/> Yourself only.....	\$ 3.45.....	\$ 7.48
	<input type="checkbox"/> Yourself plus one	\$ 6.90.....	\$ 14.95
	<input type="checkbox"/> Yourself and family.....	\$ 10.35.....	\$ 22.43
<i>Coverage is not available if you live and work in New Hampshire.</i>			
Vision	<input type="checkbox"/> No Vision		
	<input type="checkbox"/> Yourself only.....	\$ 1.00.....	\$ 2.17
	<input type="checkbox"/> Yourself plus one	\$ 1.70.....	\$ 3.68
	<input type="checkbox"/> Yourself and family.....	\$ 2.40.....	\$ 5.20
<i>Coverage is not available if you live and work in New Hampshire.</i>			
Dental	<input type="checkbox"/> No Dental		
	<input type="checkbox"/> Yourself only.....	\$ 4.45.....	\$ 9.64
	<input type="checkbox"/> Yourself plus one	\$ 8.90.....	\$ 19.28
	<input type="checkbox"/> Yourself and family.....	\$ 14.69.....	\$ 31.83
Short Term Disability (STD)	<input type="checkbox"/> No Short Term Disability		
	<input type="checkbox"/> Yourself only.....	\$ 3.50.....	\$ 7.58
	<i>Coverage is not available if you work in California, Hawaii, New Jersey, New York, Rhode Island, and Puerto Rico.</i>		
Term Life Insurance	<input type="checkbox"/> No Term Life		
	<input type="checkbox"/> Yourself only.....	\$ 1.54.....	\$ 3.34
	<input type="checkbox"/> Yourself and family.....	\$ 1.88.....	\$ 4.07

Please name your beneficiary. Beneficiary _____ Relationship: _____ Social Security Number _____

YOUR AUTHORIZATION You must sign and date this Enrollment/Change Request for all new enrollments or coverage changes.

I represent that all information supplied in this Enrollment/Change Request 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.

Your signature _____ Today's date (MM/DD/YYYY) _____

EMPLOYER GROUP INFORMATION This section is to be completed by your employer.

Employee ID _____ Hire date (MM/DD/YYYY) _____ Pay type _____ Total deduction (\$) _____ Effective date (MM/DD/YYYY) _____

Location or site code _____ Authorized signature _____ Title _____ Today's date (MM/DD/YYYY) _____

INFORMATION ABOUT YOU Repeat your name and Social Security number here.

Print your name (first, middle initial, last)

Social Security Number

INFORMATION ABOUT YOUR DEPENDENTS List the dependents for whom you are adding/changing/removing coverage.

If you have more dependents, write down their information on a separate sheet and attach it to this Enrollment/Change Request.

<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Print dependent's name (first, middle initial, last)	Social Security Number		
	Sex <input type="checkbox"/> Male / <input type="checkbox"/> Female	Date of birth	Enrolled in: <input type="checkbox"/> Medical / <input type="checkbox"/> Hospital Indemnity / <input type="checkbox"/> Vision / <input type="checkbox"/> Dental / <input type="checkbox"/> Term Life	
	Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (Specify): _____			
	Address (if different than yours)	City	State	Zip code
<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Print dependent's name (first, middle initial, last)	Social Security Number		
	Sex <input type="checkbox"/> Male / <input type="checkbox"/> Female	Date of birth	Enrolled in: <input type="checkbox"/> Medical / <input type="checkbox"/> Hospital Indemnity / <input type="checkbox"/> Vision / <input type="checkbox"/> Dental / <input type="checkbox"/> Term Life	
	Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (Specify): _____			
	Address (if different than yours)	City	State	Zip code
<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Print dependent's name (first, middle initial, last)	Social Security Number		
	Sex <input type="checkbox"/> Male / <input type="checkbox"/> Female	Date of birth	Enrolled in: <input type="checkbox"/> Medical / <input type="checkbox"/> Hospital Indemnity / <input type="checkbox"/> Vision / <input type="checkbox"/> Dental / <input type="checkbox"/> Term Life	
	Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (Specify): _____			
	Address (if different than yours)	City	State	Zip code

MAKING CHANGES OUTSIDE OF AN OPEN ENROLLMENT Please read below to see if you are able to make changes to your coverage.

You can add to or increase your coverage during the plan year only if you have a **Qualifying Life Event (QLE)**. If your deductions are taken after taxes, you may drop or decrease coverage at any time. QLEs fall under one of these two categories:

Loss of Other Coverage (LOC): If you previously declined health coverage because you or your dependents were already covered under another health plan and you or your dependents have lost that other coverage, you may be able to enroll yourself and your dependents. If you had a recent LOC, go to the list on the right and check the box next to your LOC and supply the date of the LOC.

Family Status Change (FSC): Whether you are currently enrolled or previously declined coverage, you may be able to add or increase coverage when you experience certain FSC events. If you had a recent FSC, go to the list on the right and check the box next to your FSC and supply the date of the FSC.

Next, complete the rest of this Enrollment/Change Request. When finished, make a copy and submit it to your employer with your documentation attached. You must submit this Enrollment/Change Request, together with documentation, to your employer within 30 days of the LOC/FSC.

Loss of Other Coverage (LOC):

- Divorce, legal separation or death
- Termination of employment of a dependent
- Reduction of a dependent's hours
- Termination of your or your dependents' COBRA rights
- Loss of employer's contribution to spouse's coverage
- Dependent child losing eligibility as a dependent
- Other loss of coverage

Family Status Change (FSC):

- Divorce, legal separation or death
- Marriage
- Birth or adoption of a dependent
- Other

Date of LOC or FSC (mm/dd/yyyy)