Aetna **Enrollment/Change Request**
Aetna Life Insurance Company **

EFFECTIVE DATE (MM/DD/YR)

Aetna - DMO
Dental Enrollment

Please detach this page and refer to the detailed instructions on the reverse side when completing this form.

1. Employer Name - Full Name of Business or Organization	2. Control No.	Suffix	Account	3. Plan Number	4. SFO
St. John's University	**724306**	**11**	**001**		

5. Employer Address (Street, City, State, ZIP Code) - Primary Location of Business or Organization	6. Claim Office Code	7. Customer Code (Optional)	8. Network ID
8000 Utopia Parkway, Jamaica, NY 11439			

To the Employer

Additional instructions are located on the back of this page.

- **New Enrollees:** Complete the Employer Information (Section B) of the *Enrollment/Change Request* form and reference the Instructions on the back of this page to ensure that critical information is accurate and complete.
- **Changes:** See Transaction Information (Section A) of the *Enrollment/Change Request* form and reference the Instructions on the back of this page to ensure that critical information is accurate and complete.
- **Terminations:** Be sure you sign and date the form (Section E).

To the Employee

Additional instructions are located on the back of this page.

- Please complete the entire *Enrollment/Change Request* form and reference the Instructions on the back of this page to ensure that critical information is accurate and complete.
- You are required to provide additional information for those items designated by an asterisk (*) in Section D. Note: See Instructions.
- **Be sure you sign and date the form (Section E).**

If you have questions or concerns, contact your Benefits Administrator.

Aetna

Enrollment/Change Request

Aetna Life Insurance Company **

Check One: ☐ Indemnity Dental ☐ Dental PPO ☐ Dental EPP ☒ DMO® ☐ FOC/Indemnity ☐ FOC/PPO ☐ FOC/DMO

See Instructions on the back of the front page.

A. Transaction Information

EFFECTIVE DATE (MM/DD/YR)

1. Enrollment (Check One)

☐ New Enrollee
Hire Date ___ / ___ / ___ (MM DD YR)

☐ Rehired/Reinstatement
Date ___ / ___ / ___ (MM DD YR)

☐ Return to Work
Date ___ / ___ / ___ (MM DD YR)

2. Change (From / To)

☐ Social Security Number ___ - ___ - ___ / ___ - ___ - ___
☐ Control/Suffix/Account ______ / ______
☐ Stop Continuation of Dental Coverage (i.e., COBRA)
☐ Other ______

3. Termination

☐ Terminating Employment - Reason ______
☐ Cancelling Coverage - Reason ______
☐ Continue Employee Dental Coverage (i.e., COBRA)
☐ Continue Dependent Dental Coverage (i.e., COBRA)

B. Employer Information

1. Employer Name - Full Name of Business or Organization	2. Control No.	Suffix	Account	3. Plan Number	4. SFO
St. John's University	724306	11	001		

5. Employer Address (Street, City, State, ZIP Code) - Primary Location of Business or Organization	6. Claim Office Code	7. Customer Code (Optional)	8. Network ID
8000 Utopia Parkway, Jamaica, NY 11439			

C. Employee Information - Please Print All Information

1. Employee Social Security Number	2. Employee Name (Last, First, Middle Initial)	3. Employee Home Address
- -		Number, Street, Apt

4. Employee Status	5. Sex	6. Home Telephone Number	7. Work Telephone Number	City	State	ZIP Code
☐ Active ☐ Retired		( ) -	( ) -			

D. Individuals Covered (List individuals for whom you are electing/changing coverage.)

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

* Additional information required. See Instruction page.

(A)dd/New (C)hange (R)emove	Relation. Code	Name (First, Middle Initial, Last) (Explain difference in last names in Special Remarks)	Social Security Number (If dependent has no SSN, write "None")	Birthdate MM / DD / YYYY	Dependent Address (If different than employee)	Late Entrant Yes	Prior Insur. Plan Yes*	Other Dental Coverage Yes*	Currently Covered by Medicare Yes	Handi-capped Yes*	Student Age 19 or Older Yes*	Primary Care Dentist ID # / Primary Care Dentist Name	Prev. Seen Yes
	Self		- -	/ /	Not Applicable	☐	☐	☐	☐	N/A	N/A	ID # ___ Name	☐
			- -	/ /		☐	☐	☐	☐	☐	☐	ID # ___ Name	☐
			- -	/ /		☐	☐	☐	☐	☐	☐	ID # ___ Name	☐
			- -	/ /		☐	☐	☐	☐	☐	☐	ID # ___ Name	☐
			- -	/ /		☐	☐	☐	☐	☐	☐	ID # ___ Name	☐
			- -	/ /		☐	☐	☐	☐	☐	☐	ID # ___ Name	☐

Special Remarks

E. Acknowledgments - Signatures Required

Employee's E-mail Address:

I have read and agree to the terms of the authorization on the back 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 X ______ Date ______ **Employer Signature** X ______ Date ______

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

(✓) In the area designated "Check One" in the upper left corner of the form, check box to confirm coverage requested.

A. Transaction Information

*Make sure you complete the **Effective Date** in the upper right corner of the form.*

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

To Enroll

- Complete **Effective Date** in upper right corner of form and check appropriate box in Section **A**, Number **1.**
- Complete blank fields in Section **B** (if applicable).
- Complete Section **C**, Numbers **1** through **7.**
- Complete Section **D** for all individuals for whom you are electing coverage. Complete **ALL** items for each individual listed.
- Complete **Primary Care Dentist (PCD) ID# and Name** (Section **D**) if you have chosen DMO or FOC/DMO.
- Read Section **E**. Sign name and date.

To Change

- Complete **Effective Date** in upper right corner of form and check appropriate box in Section **A**, Number **2**.
- Complete blank fields in Section **B** (if applicable).
- Complete Section **C**, Numbers **1** and **2.**
- Indicate change(s) in appropriate Section(s) (**B, C, D**) and *circle*.
- Check "Other" for dependent coverage cancellation and indicate individual(s) in Section **D**.
- Read Section **E**. Sign name and date.

To Terminate

- Complete **Effective Date** in upper right corner of form and check appropriate box in Section **A**, Number **3**.
- Indicate reason for Termination or Cancellation.
- Check appropriate box for individuals continuing dental coverage. **Note:** Section D must be completed for all individuals continuing coverage.
- Read Section **E**. 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.
B8. **Network ID** - If you have chosen DMO or FOC/DMO, record the Network ID number.

D. Individuals Covered

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.
- **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.**
- **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.
- **Birthdate** - Date of birth should include **four digit year of birth**.
- **Late Entrant** - Check "Yes" only if you are **not** enrolling within your employer's eligible enrollment period.

* **Prior Insurance Plan** - Check "Yes" if you are covered under your employer's or other prior insurance plan. NOTE: You must provide the following in Special Remarks: **Carrier/Plan Name, effective date of prior coverage, policy/group number, and prior coverage type (i.e., individual or group)**.

* **Other Dental Coverage** - Check "Yes" if you are currently covered by another dental insurance plan. NOTE: You must provide the following in Special Remarks: **Carrier Name**.

- **Currently Covered by Medicare** - Check "Yes" based on employee/dependent(s) age or disabled status.

* **Handicapped** - Check "Yes" if handicapped and financially dependent, provide proof of handicapped status from the attending physician.

* **Student Age 19 or Older** - Defined as: Unmarried dependent child age 19 or older (refer to your Summary Coverage), regularly attends school and depends solely on the enrollee for support. Member Services may request that you provide proof from the educational institution.

- **Primary Care Dentist (PCD) ID#/PCD Name** - This **must** be completed if you have chosen DMO or FOC/DMO. The PCD ID#s and PCD Names are listed in the *Provider Directory*. Check "Yes" if the PCD has been previously seen.

E. Acknowledgments

Signature Required.

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

Authorization of Enrollee

Disclosure of Healthcare Information	I authorize any physician/dentist, other healthcare professional, hospital, other healthcare institution and my employer to disclose, at any time and to the extent allowed by law, to Aetna Life Insurance Company or an affiliated entity ("Aetna"), information concerning healthcare (including dental) advice, treatment or supplies provided to my spouse or dependents or to myself, including those involving mental health, substance abuse and HIV/AIDS ("healthcare information").
Redisclosure of Healthcare Information	I also authorize Aetna to redisclose the healthcare information to my employer, healthcare professionals and institutions, independent claims administrators, utilization review organizations and reinsurers or other insurers with which Aetna has contracted.
Purpose of Disclosure/ Redisclosure	The healthcare information will be used for the coordination of patient care, administration of benefits, quality management and audit of services, and for fulfilling obligations imposed on Aetna by contract or law.
Dependents' Authorization	I have discussed the terms of this authorization with my spouse and competent adult dependents, and I have obtained their consent to the release of their healthcare information pursuant to this authorization.
Insured's Rights	I understand that I may review and offer corrections to the healthcare information, except information about me or my dependents that relates to claims or civil or criminal proceedings involving me or my dependents. I also understand I may revoke this authorization at any time, except to the extent it has been relied on by Aetna or other party. In addition, I understand that I or my designated representative may receive a copy of this authorization and that a copy of this authorization is as valid as the original.
Duration of Authorization	This authorization shall remain valid for the term of this coverage but no longer than 30 months from the date authorization is signed.
Payroll Deductions and Other Payments	I request the coverage which I have indicated and for which I am eligible. I authorize deductions from my earnings for any contributions required for healthcare coverage, and I agree to make any necessary payments as required for coverage.
Misrepresentations	It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. In addition, an insurer may deny insurance benefits if false information materially related to the claim was provided by the applicant. **Attention Florida and Virginia Residents**: Any person who knowingly and with intent to injure, 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 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. **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 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.
Independent Contractors	Applicant acknowledges that Aetna Life Insurance Company's participating providers, including all participating primary care dentists, are independent contractors and are neither agents nor employees of Aetna Life Insurance Company.

** Aetna DMO, Aetna Dental PPO, Dental EPP and Aetna Indemnity Dental are underwritten or administered by Aetna Life Insurance Company. In the states of AZ, CA, GA, MD, MO, NC, NJ and TX, Aetna DMO may also be underwritten by one of the following: Aetna Dental of California Inc., Aetna Dental Inc. (NJ), Aetna Dental Inc. (TX), Aetna Health Inc., or Aetna Health Inc. (AZ).