NOTE: Before submitting this completed form to your employer, you may wish to protect the confidentiality of your health information by taping or stapling the form so that pages 3, 4 and 5 are not visible.

aetna℠

California Small Group Business (2 - 50 Eligible Employees) Employee Enrollment/Change Form

TO COMPLY WITH CALIFORNIA LAW WHEREVER THE TERM "SPOUSE" APPEARS IT SHALL BE CONSTRUED TO INCLUDE DOMESTIC PARTNER.

Coverage is provided by the following entities: Aetna Health of California Inc. for HMO, Aetna Dental of California Inc. for Dental (DMO® only) and Aetna Life Insurance Company for all other coverages.

Group Number

Applicant Social Security Number

Company Name	**INSTRUCTIONS:** You, the employee, must complete this enrollment form in full or it will be returned to you resulting in a delay in processing. You are solely responsible for its accuracy and completeness. **If enrolling, please be sure to sign and date Employee Signature on Page 6. If waiving coverage, please complete Sections B and Declination/Waiver of Coverage on Page 6 only.**

Effective Date **Date of Hire**	☐ New Hire ☐ Rehire/Reinstatement ☐ New Group Enrollment ☐ Late Enrollment ☐ Other _____	☐ Add Spouse/Dependent Child ☐ Change of Coverage ☐ Name Change ☐ Other _____	☐ Employee Termination ☐ Remove Spouse/ Dependent Child ☐ Cancel Coverage	COBRA/Cal-COBRA for: ☐ Employee ☐ Dependent Length of Continuation: ☐ 18 ☐ 36 ☐ Other _____ Original Qualifying Event Date Qualifying Event _____

A. Coverage Selection – *Please print clearly, using black ink.*

Control/Group No.	Suffix	Account	Plan No.	Class Code

Control/Group No.	Suffix	Account	Plan No.

Control/Group No.	Suffix	Account	Plan No.

1. Medical - Check one.

HMO: ☐ 10 ☐ 20 ☐ 30 ☐ 40 ☐ 50
☐ Deductible 1000 ☐ Deductible 1500
☐ Coinsurance 70% ☐ Coinsurance 60%

Value Network℠ HMO:
☐ 10/20 ☐ 20/30 ☐ 30/40
☐ 40/50

Vitalidad Mexico HMO: ☐ 10

Basic HMO (Vitalidad Plus HMO): ☐ 10 ☐ 30

MC:
☐ 250 90/70 ☐ 2000 80/50/50
☐ 250 80/60 ☐ 2500 75/50
☐ 500 80/60 ☐ 3500 65/50
☐ 1000 70/50 ☐ 4500 60/50
☐ 750 80/50/50 ☐ 7500 75/50
☐ 1250 80/50/50 ☐ 10,000 100/50
☐ Value 2250 60/50 ☐ Value 3750 50/50
☐ HSA HDHP 2000 80/50
☐ HSA HDHP 3000 90/50
☐ HSA HDHP 3500 80/50
☐ HRA HDHP 3000 70/50

PPO: ☐ 750 80/60

Indemnity ☐

2. Dental - Check one (if applicable).

Standard Plans:
☐ Aetna Dental® Plan –
Plan Option: _____
For *FOC, choose:* ☐ DMO® or ☐ PPO

Voluntary Plans:
☐ Aetna Dental® Plan –
Plan Option: _____
For *FOC, choose:* ☐ DMO® or ☐ PPO

Before today, were you covered under this employer's dental plan? ☐ Yes ☐ No

3. Life

☐ Basic Life/AD&D Ultra®
☐ Optional Dependent Life

Beneficiary Designation -
Full Name (First, Middle, Last)

Beneficiary Social Security Number

Relationship to Employee

Whether you are enrolling or declining coverage, you must sign Page 6 of the application.

B. Employee Information - *Must be completed by the employee.*

Member Aetna ID Number (if available)	Last Name, First Name, M.I.	Job Title	Home Telephone

Home Address	Apt. No.	City, State	ZIP Code

Work Address	City, State	ZIP Code	Work Telephone

Salary: $ ☐ Hourly ☐ Monthly ☐ Weekly	Primary Language Spoken (Optional)	Number of Hours Worked Per Week	Check One ☐ Full-Time ☐ Part-Time ☐ 1099 ☐ Retiree ☐ Seasonal ☐ Temporary	Number of Dependents Including Spouse

C. Individuals Covered - ***List individuals for whom you are enrolling or adding/changing/removing coverage. Insert additional sheets if necessary. For dependents with different last names or living at another address, complete Section D below.*** **NOTE FOR MEDICAL AND DENTAL COVERAGE:** While the Federal Patient Protection and Affordable Care Act mandates coverage of dependent children up to age 26, your plan may allow coverage beyond age 26. Some exceptions apply. Please refer to your plan documents or contact your benefits administrator.

1. Employee Name (Last, First, M.I.)					Sex (M/F)	Social Security Number			
Birth date (MM/DD/YYYY)	Height (ft, in)	Weight (lbs)	Status ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Legally Separated	Coverage Election ☐ Medical ☐ Dental ☐ Life	PCP Provider Office ID Number	Current Patient ☐	Dental Office ID Number (if applicable)	Current Patient ☐	

2. Name (Last, First, M.I.)				Sex (M/F)	Social Security Number		Relationship ☐ Spouse ☐ Other _____	
Birth date (MM/DD/YYYY)	Height (ft, in)	Weight (lbs)	Coverage Election ☐ Medical ☐ Dental ☐ Life	PCP Provider Office ID Number	Current Patient ☐	Dental Office ID Number (if applicable)	Current Patient ☐	

3. Child Name (Last, First, M.I.)				Sex (M/F)	Social Security Number		Relationship ☐ Child ☐ Stepchild ☐ Other _____	
Birth date (MM/DD/YYYY)	Height (ft, in)	Weight (lbs)	Coverage Election ☐ Medical ☐ Dental ☐ Life	PCP Provider Office ID Number	Current Patient ☐	Dental Office ID Number (if applicable)	Current Patient ☐	

4. Child Name (Last, First, M.I.)				Sex (M/F)	Social Security Number		Relationship ☐ Child ☐ Stepchild ☐ Other _____	
Birth date (MM/DD/YYYY)	Height (ft, in)	Weight (lbs)	Coverage Election ☐ Medical ☐ Dental ☐ Life	PCP Provider Office ID Number	Current Patient ☐	Dental Office ID Number (if applicable)	Current Patient ☐	

5. Child Name (Last, First, M.I.)				Sex (M/F)	Social Security Number		Relationship ☐ Child ☐ Stepchild ☐ Other _____	
Birth date (MM/DD/YYYY)	Height (ft, in)	Weight (lbs)	Coverage Election ☐ Medical ☐ Dental ☐ Life	PCP Provider Office ID Number	Current Patient ☐	Dental Office ID Number (if applicable)	Current Patient ☐	

D. Dependent Information

List any dependent in Section C living at another address.	Name:	Reason:	Address:
If any dependent's last name differs from yours, explain.	Name:	Reason:	

For Dependent Life: If age 19 and over and a full-time student, provide the following:

Child Name	School Name	Expected Graduation Date	Number of Credit Hours

E. Medicare Information

Name of Person	Medicare Part A	Medicare Part B	Medicare Part D	Over Age 65	Disability	End-Stage Renal Disease Effective Date
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

F. Other Insurance

Does anyone age 19 and over enrolling on this enrollment form have current or prior coverage? ☐ Yes ☐ No

Proof of coverage should accompany this enrollment form for pre-existing condition credit and if an employee is waiving coverage. **Acceptable forms of proof are:**

1. Certificate of Creditable Coverage from prior carrier, or
2. Copy of ID card or most recent payroll stub showing medical coverage deduction, or
3. Copy of most recent medical premium bill from prior carrier.

Failure to provide Proof of Prior Coverage may subject you or a family member (age 19 and over) to the full pre-existing conditions limitation with no credit for prior coverage. You may request a Certificate of Creditable Coverage from your prior carrier. NOTE: If your Plan contains a pre-existing conditions provision, the pre-existing conditions exclusion and limitation will not apply to a person under 19 years of age.

Name of Covered Individual	Carrier Name	Group Number	Start Date	Termination Date	Health
					☐ Yes ☐ No
					☐ Yes ☐ No

G. Health Questionnaire for Groups Enrolling 2 - 10 Eligible Employees (and employees of groups enrolling for Life coverage greater than the Guaranteed Issue Level)

Health History for Individuals and your Dependents. *The following information is confidential and will not be seen by or given to your employer.*

- ALL of the questions must be answered by you and your dependents or your enrollment form will be returned.
- Incomplete enrollment forms may delay the effective date of your coverage.

In the past **five (5)** years, has any person enrolling for this coverage consulted with or been examined or treated by any health care professional for any illness, injury, or health condition listed below? Check all that apply.

1. Circulatory ☐ Yes ☐ No

☐ Ablation ☐ Anemia ☐ Aneurysm ☐ Angina ☐ Angioplasty ☐ Blood Clot ☐ TIA ☐ Arrhythmia ☐ Blood Disorder
☐ Blood Vessels ☐ Bypass ☐ CAD ☐ Chest pain ☐ Heart Attack ☐ Heart Disease ☐ Heart Murmur ☐ Hemophilia ☐ ICD Implant
☐ Palpitations ☐ Phlebitis ☐ Skin Ulcer ☐ Stroke ☐ Stent ☐ High Blood Pressure ☐ High Cholesterol ☐ High Triglycerides ☐ Sickle Cell Anemia
☐ Varicose Veins ☐ Tachycardia ☐ Heart Valve Disorder ☐ Pacemaker - Reason inserted _____ ☐ Peripheral Vascular Disease ☐ Congestive Heart Failure ☐ Irregular Heart Beat

2. Intestinal ☐ Yes ☐ No

☐ Cirrhosis ☐ Colitis ☐ Crohn's ☐ GERD ☐ Diverticulitis
☐ Gallbladder ☐ Hernia ☐ Polyp ☐ Reflux ☐ Pancreatitis
☐ Tumor ☐ Ulcer ☐ Ulcerative Colitis ☐ Gastric Bypass/Stapling ☐ Colon Disorder
☐ Colostomy: ☐ Total or ☐ Partial ☐ Ileostomy: ☐ Total or ☐ Partial

3. Kidney/Urinary/ Bladder ☐ Yes ☐ No

☐ Bladder Disorder ☐ Kidney Disorder ☐ Polycystic Kidney ☐ Prostate Disorder
☐ Kidney Stone(s) Present ☐ Yes ☐ No How many passed _____ Date last stone passed or surgically removed _____ ☐ Dialysis - Date started _____
☐ Renal Failure ☐ Polyp ☐ End Stage Renal Disease

4. Respiratory ☐ Yes ☐ No

☐ Asthma ☐ Mild ☐ Moderate ☐ Severe Date of last ER visit _____ ☐ Injections - How often _____
☐ Allergies ☐ Injections - How often _____
☐ COPD/Emphysema - On Oxygen ☐ Yes ☐ No
☐ Sleep Apnea: ☐ CPAP or ☐ BiPap ☐ Chronic Bronchitis ☐ Cystic Fibrosis ☐ Lung Disorder ☐ Pneumonia ☐ Polyp
☐ Sarcoidosis ☐ Tuberculosis ☐ Valley Fever ☐ Tumor ☐ Growth ☐ Cyst

5. Brain ☐ Yes ☐ No

☐ Acoustic Neuroma ☐ Alzheimer ☐ Concussion ☐ Paralysis ☐ Parkinson's Disease ☐ ALS/Lou Gehrig's Disease
☐ Brain/Head Injury Complications ☐ Yes ☐ No ☐ Migraines Date of last ER visit _____ ☐ Cyst ☐ Hemiplegia ☐ Quadraplegia
☐ Multiple Sclerosis ☐ Tumor ☐ Growth ☐ Seizures/Epilepsy Date of last seizure _____ Date diagnosed _____

6. Cancer ☐ Yes ☐ No

☐ Basal cell ☐ Bladder ☐ Blood ☐ Bone ☐ Breast ☐ Brain
☐ Cervical ☐ Colon ☐ Eye ☐ Liver ☐ Lung ☐ Ovarian
☐ Prostate ☐ Stomach ☐ Thyroid ☐ Testicular ☐ Lymph System ☐ Esophageal
☐ Leukemia ☐ Lymphoma ☐ Hodgkin's Disease ☐ Melanoma ☐ Metastasized ☐ Squamous cell
☐ Surgery ☐ Chemo ☐ IV Chemo ☐ Radiation ☐ Stage _____

7. Mental Health ☐ Yes ☐ No

☐ Alcohol Abuse ☐ Anorexia ☐ Anxiety ☐ ADD/ADHD
☐ Autism ☐ Counseling ☐ Drug Abuse ☐ Cocaine use
☐ Marijuana use ☐ Opiate use ☐ Heroin use ☐ Methadone use
☐ Morphine use ☐ Bipolar ☐ Bulimia ☐ Depression
☐ Manic Depressive ☐ Schizophrenia ☐ Suicide Attempt

8. Reproductive ☐ Yes ☐ No

☐ Abnormal Pap ☐ Breast Disorder ☐ Cyst ☐ Endometriosis ☐ Fibroids
☐ Growth ☐ Infertility ☐ HPV ☐ Menstrual Disorder ☐ Ovarian Cysts
☐ Polycystic Ovarian Syndrome ☐ Pregnant - Due date _____ ☐ C section planned ☐ Yes ☐ No ☐ Multiples Expected (# _____) ☐ Complications: ☐ Present ☐ Past
☐ STD ☐ Tumor ☐ Polyp ☐ Other _____

9. Transplant ☐ Yes ☐ No

☐ Bone ☐ Bone Marrow ☐ Cornea
☐ Heart ☐ Heart Valve ☐ Intestine
☐ Liver ☐ Lung (single) ☐ Lung (double)
☐ Pancreas ☐ Skin ☐ Stem Cell
☐ Pending ☐ On Waiting List ☐ Recommended

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS ABOVE, YOU MUST COMPLETE SECTION I ON PAGE 5.

G. Health Questionnaire for Groups Enrolling 2 - 10 Eligible Employees (and employees of groups enrolling for Life coverage greater than the Guaranteed Issue Level) *Continued*

10. Bones/ Muscles/Joint ☐ Yes ☐ No	☐ Back/Neck Disorder ☐ Breast Implants ☐ Chiro adjustments ☐ Physical Therapy ☐ Chronic Fatigue ☐ Carpal Tunnel ☐ Arthritis ☐ Rheumatoid Arthritis ☐ Osteoarthritis ☐ Congenital Disorder ☐ Fibromyalgia ☐ Gout ☐ Pins, screws, plates ☐ Permanent ☐ Temporary ☐ Knee Disorder ☐ Shoulder ☐ Muscular Dystrophy ☐ Amputation Body part _____ ☐ Fracture Location _____ ☐ Joint Replacement Location _____ ☐ Spina Bifida ☐ Sprain/Strain Location _____ ☐ Prosthetic Device Body part _____
11. Endocrine/ Metabolic ☐ Yes ☐ No	☐ Diabetes Date diagnosed _____ ☐ Diet ☐ Insulin ☐ Oral medication ☐ Other _____ ☐ Adrenal Gland ☐ Gaucher's Disease ☐ Goiter ☐ Growth Disorder ☐ Graves Disease ☐ Hashimoto Disease ☐ Hepatitis ☐ A ☐ B ☐ C ☐ Other _____ ☐ Hypothyroid ☐ Hyperthyroid ☐ Liver Disorder ☐ Pituitary ☐ Thyroid Disorder ☐ Tumor ☐ Growth ☐ Cyst
12. Immune ☐ Yes ☐ No	☐ AIDS ☐ Herpes ☐ Hepatitis Exposure ☐ Immune Deficiency ☐ Lupus: ☐ Discoid or ☐ SLE ☐ Scleroderma
13. Birth Defects/ Congenital Abnormalities ☐ Yes ☐ No	☐ Birthmarks ☐ Cerebral Palsy ☐ Cleft Palate/Lip ☐ Club Foot ☐ Webbed Fingers/Toes ☐ Developmental Delay ☐ Mental Retardation ☐ Down's Syndrome ☐ Heart/Lung Malformation ☐ Premature birth still receiving treatment ☐ Skull/Facial or other physical deformities
14. Eyes/Ears/ Nose/Skin ☐ Yes ☐ No	☐ Acne ☐ Cataracts ☐ Eczema ☐ Chronic Ear Infections ☐ Chronic Sinusitis ☐ Deviated Septum ☐ Glaucoma ☐ Psoriasis ☐ Retinal Disorder ☐ Burns: ☐ 1st degree ☐ 2nd degree ☐ 3rd degree
15. Medication(s) ☐ Yes ☐ No	☐ Currently taking prescription medications ☐ Stopped taking prescription medications within the past year
16. Other ☐ Yes ☐ No	☐ Abnormal tests or physical results ☐ Condition or disorder not listed above ☐ Hospitalized ☐ Surgery ☐ Injections – what for _____ ☐ Tests results pending ☐ Claims in excess of $5,000 in the past 24 months ☐ Chiropractic adjustments for maintenance ☐ Physical deformity or defect ☐ Non ambulatory, wheel chair bound ☐ Use of assistive crutches/walker ☐ Workers' Comp injury or illness ☐ Tests, treatment or surgery discussed or advised, not yet done ☐ Tumor - location _____ ☐ Growth - location _____ ☐ Cyst - location _____ ☐ Polyp - location _____ ☐ Other _____
17. Tobacco ☐ Yes ☐ No	☐ Employee: ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Chewing Tobacco ☐ Spouse: ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Chewing Tobacco

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS ABOVE, YOU MUST COMPLETE SECTION I ON THE FOLLOWING PAGE.

H. Health Questionnaire for Groups Enrolling 11 - 50 Eligible Employees (and employees of groups enrolling for Life coverage greater than the Guarantee Issue Level) *Continued on Page 5*

Health History for Employees and your Dependents. ***The following information is confidential and will not be seen by or given to your employer.***

- ALL of the questions must be answered by you or your dependents or the enrollment form will be returned.
- Incomplete enrollment forms may delay the effective date of your coverage.

Answer all questions.

1. Within the last **5** years has anyone applying for coverage consulted, received treatment, by a doctor, psychiatrist, psychologist, or other practitioner or been diagnosed with any of the following conditions or disorders? (Check all that apply.) ☐ Yes ☐ No

a. ☐ AIDS
b. ☐ Diabetes
c. ☐ Infertility
d. ☐ Endocrine/Metabolic
e. ☐ Pancreas
f. ☐ Liver/Hepatitis
g. ☐ Immune System (other than HIV)
h. ☐ Blood Disorder
i. ☐ Epilepsy/Seizure
j. ☐ Heart
k. ☐ Paralysis/Paresis
l. ☐ Tumor/Cyst/Growth
m. ☐ Systemic or Discoid Lupus
n. ☐ Lung or Respiratory
o. ☐ Alcohol or Drug Use
p. ☐ Kidney/Bladder/Urinary
q. ☐ Circulatory/Vascular
r. ☐ Digestive/Stomach/Intestinal
s. ☐ Central Nervous System
t. ☐ Pituitary/Adrenal/Growth Disorder
u. ☐ Birth Defects/Congenital Abnormalities
v. ☐ Arthritis/Bone/Joint/Muscle/Prosthetic Device
w. ☐ Mental/Nervous/Emotional/Eating Disorder
x. ☐ Stroke/Brain/Neurological
y. ☐ Transplant: ☐ Recommended ☐ Pending ☐ Complete
z. ☐ Advised to have surgery or course of treatment not yet determined
aa. ☐ Cancer: Type:_____ Stage _____
bb. ☐ Using: ☐ Crutches ☐ Walker ☐ Wheelchair ☐ Surgery ☐ Chemo ☐ Radiation

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS ABOVE, YOU MUST COMPLETE SECTION I ON PAGE 5.

H. Health Questionnaire for Groups Enrolling 11 - 50 Eligible Employees (and employees of groups enrolling for Life coverage greater than the Guarantee Issue Level) *Continued from Page 4*

2.	Is any female currently pregnant? If so, provide due date _____ Check applicable boxes: ☐ C section planned ☐ Multiple Births Expected (# ____) ☐ Complications: ☐ Past or ☐ Present	☐ Yes ☐ No
3.	Has anyone applying for coverage incurred medical expenses in excess of $5,000 in the past 24 months?	☐ Yes ☐ No
4.	Has anyone applying for coverage been prescribed medications in the past 12 months?	☐ Yes ☐ No
5.	Does anyone applying for coverage have a known condition that requires on-going treatment?	☐ Yes ☐ No
6.	Do you or your spouse use tobacco products? If so, check the applicable boxes: ☐ Employee: ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Chewing Tobacco ☐ Spouse: ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Chewing Tobacco	☐ Yes ☐ No

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS ABOVE, YOU MUST COMPLETE SECTION I BELOW.

I. Health Questionnaire – Details for "Yes" Responses in Section G or H.

Provide details below to any boxes checked above in Section G or H. ***(If additional space is needed, attach a separate sheet and be sure to sign and date the sheet.)***

Question Number	Name of Individual	Condition/Diagnosis	Date of Onset	Date Treatment Ended	Names of Prescription Medication	Dosage	Still Taking Medication
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

If you are providing additional sheets, check here ☐ ***and insert the sheets before sealing this Enrollment form.***

Conditions of Enrollment

NOTICE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

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

1. I acknowledge that by enrolling in the following plans, coverage is provided by the following entities (collectively referred to as "Aetna"):
   - Aetna HMO: Aetna Health of California Inc.
   - Aetna Dental DMO: Aetna Dental of California Inc.
   - Life, Accidental Death & Dismemberment, Dental and all other health coverages: Aetna Life Insurance Company.
2. I understand and agree that my employer's application will determine coverage and that there is no coverage unless and until both the eligible employee enrollment form and employer applications have been accepted and approved by Aetna. Even if this enrollment form is approved, any misstatements or omissions, **except with regards to health status related factors**, may result in future claims being denied and the policy or my coverage under the policy being reevaluated, as of the effective date, for eligibility and rating purposes. **For life coverages:** 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 benefit 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. For Dependent Life, dependents are eligible from 14 days of age up to their 19th birthday, or up to their 23rd birthday, if a full-time student.
3. I understand and agree that this enrollment form may be transmitted to Aetna or its agent by my employer or its agent. I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("Providers"), including pharmacies or pharmacy database benefit managers to give to Aetna or its agent information concerning the medical history, prescription utilization history, services or treatment provided to anyone listed on this Enrollment/Change Form, including those involving mental health, substance abuse and AIDS. I further authorize Aetna to use such information and to disclose such information to affiliates, Providers, payors, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. I have discussed the terms of this authorization with my spouse and competent adult dependents, and I have obtained their consent to those terms. I understand that this authorization is provided under state law, and that it is not an "authorization" within the meaning of the federal Health Insurance Portability and Accountability Act. This authorization is valid for term of the coverage and so long thereafter as allowed by law. I understand that I am entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original.

continued on Page 6

Conditions of Enrollment *(continued)*

4. 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 plan.
5. I understand and agree that, with the exception of Aetna Rx Home Delivery®, all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.
6. I understand and agree that, with certain exceptions described in the plan documents, HMO and DMO® plans only provide coverage for referred benefits, and that, in order to be covered, services must be performed either by a participating primary care physician, primary care dentist, or by the participating specialist, hospital, pharmacy, dentist, or other provider as authorized by a referral from a participating primary care physician.
7. I understand and agree that, as described in the plan documents and when enrolled for medical coverage, any pre-existing conditions for my spouse, dependents or myself may not be covered for 6 months. NOTE: If your Plan contains a pre-existing conditions provision, the pre-existing conditions exclusion and limitation will not apply to a person under 19 years of age.

Misrepresentation

8. **Attention California Residents**: **For your protection, California law requires notice of the following to appear on this form:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

To the best of my knowledge, I represent that all information supplied in this form is true and complete. I have read and agree to the Conditions of Enrollment and Misrepresentation on this **California** Small Group Business (2 - 50 Eligible Employees) Employee Enrollment/Change Form. I understand in the event I fail to sign and return this form within 31 days of my eligibility date or 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. I am employed by the employer shown on Page 1, and I am working full time at least 30 hours per week for this employer at the regular place of business.

CA HMO ENROLLEES - NOTICE OF BINDING ARBITRATION: ANY DISPUTE ARISING FROM OR RELATED TO HEALTH PLAN MEMBERSHIP WILL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION, AND NOT BY A LAWSUIT OR RESORT TO COURT PROCESS EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. THE AGREEMENT TO ARBITRATE INCLUDES, BUT IS NOT LIMITED TO, DISPUTES INVOLVING ALLEGED PROFESSIONAL LIABILITY OR MEDICAL MALPRACTICE, THAT IS, WHETHER ANY MEDICAL SERVICES COVERED BY THIS AGREEMENT WERE UNNECESSARY OR WERE UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED. THE HEALTH PLAN AGREEMENT ALSO LIMITS CERTAIN REMEDIES AND MAY LIMIT THE AWARD OF PUNITIVE DAMAGES. SEE THE EVIDENCE OF COVERAGE FOR FURTHER INFORMATION.

I understand that I am giving up the constitutional right to have disputes decided in a court of law before a jury, and instead am accepting the use of binding arbitration. This means that members will not be able to try their case in court. I further understand that the agreement contains limitations on certain remedies and that there may be certain limitations to the recovery of punitive damages.

☐ **I AM ENROLLING FOR COVERAGE:** ***Employee Signature*** **X**	***Employee E-mail Address (optional)***	***Date (Month/Day/Year)***

Declination/Waiver of Coverage - ***To be completed if medical and/or dental coverage is declined or refused by an eligible employee and/or their eligible family members.***

I understand I am eligible to apply for this coverage through my employer; however, I am waiving coverage as noted below.

☐ Employee	☐ Medical	☐ Dental	☐ Life	**Reason for declining coverage** (*If applicable attach front/back of your health ID card.*): ☐ Covered by spouse's group coverage - Carrier Name and ID number: _____ ☐ Enrolled in other insurance (check applicable box): ☐ Medicare ☐ TRICARE ☐ CHAMPVA ☐ Military ☐ Individual ☐ COBRA ☐ Retiree ☐ Other_____ ☐ Carrier Name and ID number: _____ ☐ Spouse covered by employer's group coverage ☐ Do Not Want
☐ Spouse	☐ Medical	☐ Dental	☐ Life	
☐ Child(ren)	☐ Medical	☐ Dental	☐ Life	

I certify I have been given the right to apply for this coverage; however, I am electing not to enroll. By declining this group coverage I acknowledge that I and/or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage. Pre-existing conditions, when enrolled in this plan, may not be covered for six months. NOTE: If your Plan contains a pre-existing conditions provision, the pre-existing conditions exclusion and limitation will not apply to a person under 19 years of age.

Please sign here ONLY if you are declining coverage for yourself and/or your dependent(s). ☐ I AM DECLINING COVERAGE: **Employee Signature** **X**	***Date (Month/Day/Year)***

DMHC Written Notice of Availability of Language Assistance

HMO and DMO-based plans - **IMPORTANT:** Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-877-287-0117.

Planes basados en DMO y HMO - **IMPORTANTE:** ¿Puede leer esta carta? En caso de no poder leerla, le brindamos nuestra ayuda. También puede obtener esta carta escrita en su idioma. Para obtener ayuda gratuita, por favor llame de inmediato al 1-877-287-0117.

Traditional Plans:

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-877-287-0117. For more help call the CA Dept. of Insurance at 1-800-927-4357 English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-877-287-0117. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

免費語言服務。您可獲得口譯員服務，用中文把文件唸給您聽。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打 1-877-287-0117 與我們聯絡。欲取得其他協助，請致電1-800-927-4357 與加州保險部聯絡。Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch và được người khác đọc giúp các tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-877-287-0117 . Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese.

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Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-877-287-0117. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-877-287-0117 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-877-287-0117. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または1-877-287-0117までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Japanese

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره 1-877-287-0117 تماس بگیرید. برای دریافت کمک بیشتر، به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تلفن کنید. Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-877-287-0117 'ਤ ਸਾਨ ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

េសវាកម្មភាសាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមាន បង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-877-287-0117 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា

តាមលេខ 1-800-927-4357 Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-877-287-0117 . للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357.Arabic

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-877-287-0117. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

CDI Notice of Language Assistance-Trad