CBR creative business resources

Dental and Vision Enrollment

GROUP HEALTH BENEFIT ENROLLMENT & CHANGE FORM

Aetna

GROUP # 0710010 **DIVISION** _____

Client Company _____

Do Not Write in this Area - For Aetna Group Use Only
Dep_____ Rx_____ ID _____ Misc _____ Eff. Date _____/_____

Employee Information

Employee Last name	First Name	Middle Initial	Date of Full Time Employment (M/D/Y)	Date Eligible for Benefits (M/D/Y)

Mailing Address	Social Security #

City	State	Zip

Gender ☐ F ☐ M	Date of Birth (Month Day Year)	Daytime Phone Number	Marital Status ☐ S ☐ M ☐ W ☐ D

Elections & Dependent Information (Employee Enrollment Required)

Reason for Enrollment: ☐ New Hire ☐ Open Enrollment Period ☐ Marriage ☐ Birth/Adoption ☐ Divorce ☐ Other_____

☐ Loss of other Group Health Coverage (proof required)

Employee Coverage Desired:

☐ Dental ☐ Vision

Reason for Termination of Coverage: ☐ Divorce ☐ Dependent Child reached limiting age ☐ Death ☐ Termination of Employment ☐ Other_____ _____

Date of Marriage, Birth/Adoption, Loss of Other Coverage, Divorce, Death or Child Reached Limiting Age:_____

Have you or your dependents had insurance within the last 62 days? ☐ Yes (Please provide creditable coverage letter) ☐ No

ENROLLMENT OR TERMINATION: Complete this section for **each** person who wants to enroll (add) or drop coverage

		First and Last Name	MI	Gender	DOB	SS#	Child lives with employee?	Indicate A = Add D = Drop	Type of coverage (check all that apply) Medical	Dental
1	Employee									
2	Spouse									
3	Child									
4	Child									
5	Child									
6	Child									

Dental & Vision

Dental	PPO Plan
	Plan 1

	Monthly Premium
Employee Only	$28.47
Employee + Spouse	$54.20
Employee + Child(ren)	$45.52
Family	$81.31

Vision	Eyemed
	Plan 2

	Monthly Premium
EE	$7.96
ES	$14.73
EC	$15.52
F	$19.01

If this section is not completed, the processing of your claims may be delayed

	Medical	Dental
Name & Date of Birth for Policy Holder		
Other Insurance Name		
Effective Date of Policy		
Termination Date of Policy		

I represent that all information supplied in this form is true and complete. I have read and agree to the Conditions of Enrollment on this **Arizona** Group Business (2 - 100 Eligible Employees) Employee Enrollment/Change Form. I understand that, in the event I fail to sign this form within 31 days after the above transaction request 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 this page at the regular place of business. Health Insurance Premiums are collected a month in advance. Benefits end on the last day of the month after termination of employment.

Employee Signature ***X***	***Employee Email Address (optional)***	***Date (Month/Day/Year)***