



Disability Enrollment/Change Request

Aetna Life Insurance Company

A. Transaction Information - Based on the requirements of your plan, you may be required to submit evidence of good health.

Effective Date (MM/DD/YYYY) _____ Date of Hire (MM/DD/YYYY) _____	<input type="checkbox"/> Short Term Disability - Indicate transaction below.		<input type="checkbox"/> Long Term Disability - Indicate transaction below.	
	<input type="checkbox"/> Add Coverage	<input type="checkbox"/> Terminate Coverage (Cancel)	<input type="checkbox"/> Add Coverage	<input type="checkbox"/> Terminate Coverage (Cancel)
	<input type="checkbox"/> Increase Coverage _____ <small>Indicate Plan Name</small>	<input type="checkbox"/> Decrease Coverage _____ <small>Indicate Plan Name</small>	<input type="checkbox"/> Increase Coverage _____ <small>Indicate Plan Name</small>	<input type="checkbox"/> Decrease Coverage _____ <small>Indicate Plan Name</small>

B. Employer Information - Please Print all Information

1. Employer Name - Full Name of Business or Organization		2. Control No.	Suffix	Account	3. Plan Number	4. SFO
5. Employer Address (Street, City, State, ZIP Code) - Primary Location of Business or Organization					6. Claim Office Code	7. Customer Code (Optional)

C. Employee Information - Please Print all Information

1. Employee Social Security Number - -	2. Employee Name (Last, First, M.I.)	3. Birthdate (MM/DD/YYYY) / /	4. Sex	5. Telephone Numbers Home () - Work () -
6. Employee Home Address (Number, Street, Apt. No., City, State, ZIP Code)				7. Employee Annual Earnings \$
				8. Occupation/Title
				9. Work State

D. Certification - Signatures Required

I certify that all information on this form is true and complete to the best of my knowledge and belief. I understand that this insurance is subject to all of the terms of the Plan of Insurance contained in the group policy and summarized in the announcement material provided me and the certificate issued to me. 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 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.

I understand that, in the event I fail to sign this form within 31 days of the effective date of eligibility or that for any reason Aetna does not receive notice of the Enrollment/Change Request within a reasonable time following the event, my and my dependents' eligibility may be affected. I request my employer to arrange for the issuance of Group Disability Coverage for which I am or may become eligible and authorize deductions of the required contributions from my earnings.

Misrepresentations: 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.

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. Many other states have similar laws.

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 Florida and Virginia Residents: Any person who knowingly and with intent to 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 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.

My signature below signifies my agreement with the statements and authorization above.

Employee Signature (Required) X	Date	Employer Signature (Required) X	Date
Employee E-mail Address	Name (please print)		Title

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

A. Transaction Information

*Make sure you complete the **Effective Date** in Section A - Transaction Information.*

*Make sure you read Section D. **Sign Name and Date.***

To Enroll

- Complete **Effective Date** and **Date of Hire** in Section A - Transaction Information.
- Check the box(es) applicable to the benefit(s) you wish to enroll for in Section A - Transaction Information and check **Add Coverage**.
- Complete **all** blank fields in Section B - Employer Information and Section C - Employee Information.
- Make sure you read Section D - Certification. **Sign Name and Date.**

To Terminate Coverage (Cancel)

- Check the box(es) applicable to the benefit(s) you wish to terminate in Section A - Transaction Information and check **Terminate Coverage (Cancel)**.
- Complete all blank fields in Section B - Employer Information *and* Section C - Employee Information.
- Make sure you read Section D - Certification. **Sign Name and Date.**

To Change

NOTE: All changes require the completion of the **Effective Date** and **Employee Social Security Number**.

- Increase Coverage

- Check the box(es) applicable to the benefit(s) you wish to increase coverage of in Section A - Transaction Information.
- Check **Increase Coverage** and provide the new plan name or the amount of coverage you are increasing to in Section A.
- Complete **all** blank fields in Section B - Employer Information *and* Section C - Employee Information.
- Make sure you read Section D - Certification. **Sign Name and Date.**

- Decrease Coverage

- Check the box(es) applicable to the benefit(s) you wish to decrease coverage of in Section A - Transaction Information.
- Check **Decrease Coverage** and provide the new plan name or the amount of coverage you are decreasing to in Section A.
- Complete **all** blank fields in Section B - Employer Information *and* Section C - Employee Information.
- Make sure you read Section D - Certification. **Sign Name and Date.**

- Change Employee Information

- Check the applicable box(es) in Section A - Transaction Information.
- Complete all blank fields in Section B - Employer Information.
- Complete Section C - Employee Information.

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.

C. Employee Information

To be completed by the Enrollee.

C3. **Birthdate** - Date of birth should include **four digit year of birth**.

D. Certification

Signatures Required

- Read the information contained above the space provided for your signature in Section D and the information on the back of the form.
- **Sign name and date the form.**