



Employee Enrollment/ Change Form

INSTRUCTIONS:

You alone are responsible for its accuracy and completeness.
declining coverage, you must complete Section F.

If you are

Group number
Aetna member ID number (if available)

Company name J. Sterling Morton High School District #201			
Effective date	☐ New hire ☐ Rehire / reinstatement ☐ New group enrollment ☐ Late enrollment	☐ Add spouse ☐ ☐ Add dependent child ☐ Change of coverage ☐ Name change	☐ Employee termination date _____ ☐ Remove spouse ☐ ☐ Remove dependent child ☐ Cancel coverage ☐ Other _____
Date of hire	☐ Waiver ☐ Open enrollment ☐ Loss of coverage		
☐ COBRA ☐ State continuation for: ☐ Employee ☐ Dependent Length of continuation: ☐ 18 months ☐ 36 months ☐ Other _____ Qualifying event _____ Original qualifying event date _____ Loss of coverage date _____			

A. Employee information - You must complete this section.

Social Security number	Last name, first name, middle initial		Job title	
Home address		Apt. number	City, state	ZIP code
Work address		City, state		ZIP code
Home telephone () -	Work telephone () -	Primary language spoken (optional)		Number of hours worked a week
Check one ☐ Full time ☐ 1099 ☐ Seasonal ☐ COBRA / State continuation ☐ Part time ☐ Retiree ☐ Temporary ☐ Union				Number of dependents, including spouse, civil union partner or domestic partner enrolling for medical coverage

Continued on next page

Control/Group number	Suffix	Account	Plan number
2. Dental ☐ Yes ☐ No To enroll, enter the plan number and name below.			
– Plan number _____ Plan name _____ ☐ PPO			
Before today, were you covered under this employer's dental plan? ☐ Yes ☐ No			
Aetna Life Insurance Company underwrites Aetna Dental plans.			

1	☐ Add ☐ Change ☐ Remove	Employee name (Last, first, middle initial)			Sex (M/F)	
	Birthdate (MM/DD/YYYY) / /	Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally separated	Choosing coverage for: ☐ Dental			
2	☐ Add ☐ Change ☐ Remove	Name (Last, first, middle initial) ☐ Spouse			Sex (M/F)	Social Security number
	Birthdate (MM/DD/YYYY) / /	Choosing coverage for: ☐ Dental				
3	☐ Add ☐ Change ☐ Remove	Name (Last, first, middle initial) ☐ Child ☐ Stepchild ☐ Other _____			Sex (M/F)	Social Security number
	Birthdate (MM/DD/YYYY) / /	Status ☐ Different last name ☐ Incapacitated ☐ Military veteran	Choosing coverage for: ☐ Dental			
4	☐ Add ☐ Change ☐ Remove	Name (Last, first, middle initial) ☐ Child ☐ Stepchild ☐ Other _____			Sex (M/F)	Social Security number
	Birthdate (MM/DD/YYYY) / /	Status ☐ Different last name ☐ Incapacitated ☐ Military veteran	Choosing coverage for: ☐ Dental			

2

5	☐ Add ☐ Change ☐ Remove	Name (Last, first, middle initial)	☐ Child ☐ Other _____	☐ Stepchild	Sex (M/F)	Social Security number
Birthdate (MM/DD/YYYY) / /		Status ☐ Different last name ☐ Incapacitated ☐ Military veteran	Choosing coverage for: ☐ Dental			

6	☐ Add ☐ Change ☐ Remove	Name (Last, first, middle initial)	☐ Child ☐ Other _____	☐ Stepchild	Sex (M/F)	Social Security number
Birthdate (MM/DD/YYYY) / /		Status ☐ Different last name ☐ Incapacitated ☐ Military veteran	Choosing coverage for: ☐ Dental			
						Yes

D. Dependent information

List any dependent in Section C living at another address.	
Name	Address

E. Coordination of benefits

Will you have other health insurance at the same time as this coverage? ☐ Yes ☐ No If yes , will the Aetna coverage you're applying for replace the coverage you have now? ☐ Yes ☐ No			
Name of person	Carrier name	Name of person	Carrier name

F. Declining coverage – Check all that apply.

I understand I am eligible to apply for this coverage through my employer. However, I am declining the coverage I checked below:			
☐ Employee:	☐ Dental	Reason for declining coverage ☐ Parental group coverage ☐ Spouse ☐ Medicare ☐ Medicaid ☐ Retiree coverage ☐ COBRA / state continuation coverage ☐ Insurance through another job ☐ TRICARE / Military coverage ☐ Individual coverage – On Exchange ☐ Individual coverage – Off Exchange ☐ Another group plan provided by my employer ☐ Do not want ☐ Other _____	
☐ Spouse	☐ Dental		
☐ Children:	☐ Dental		
I certify I have the right to apply for this coverage. However, I am declining coverage as noted above. 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.			
Please sign here ONLY if you are declining coverage for yourself and / or dependents.			Date (Month/Day/Year)
☐ I am declining coverage. Employee signature: X			
Please PRINT employee name:			

Please sign here **ONLY** if you are enrolling in coverage for yourself and / or dependents.

Employee signature (required)

Date (Month/Day/Year)

X