aetna®

Dental Enrollment/Change Request

Aetna Life Insurance Company *

Employer Group Information: (To Be Completed by Employer)	Employer Name - Full Name of Business or Organization	Control	Suffix	Account	Plan Number
	RIDER UNIVERSITY	884014	31		
	Employer Address (Street, City, State, ZIP Code) - Primary Location of Business or Organization				

A. Type of Activity - Employee Completes Sections A - E. *Please Print Clearly.*

Instructions: Refer to the instructions on the back before completing this form. You, the employee, must complete this application in full or it will be returned to you resulting in a delay in processing. You are solely responsible for its accuracy and completeness.

Enrollment - *Check one.*
☐ New Enrollee/Subscriber ☐ Rehire/Reinstatement
Effective Date / / Date of Rehire/Reinstatement / /
Date of Hire / /

Change - *Check all that apply.*
☐ Add Spouse ☐ Add Dependent Child ☐ Name Change ☐ Other ☐ Control/Suffix/Acct/Plan
Date of Event / / Reason

Remove or Terminate - *Check all that apply.*
☐ Remove Spouse ☐ Remove Dependent Child ☐ Employee Withdrawal/ Termination ☐ Cancel Coverage
Effective Date / / Reason

Continuation of Coverage, i.e., COBRA, State - *Not all options are available. Contact Employer for available options.*
Coverage For: ☐ Employee ☐ Dependents
Length of Continuation (months): ☐ 18 ☐ 36 ☐ Other ____
☐ 29 - Attach disability determination from the Social Security Admin.
Date of Loss of Coverage / / Date of Qualifying Event / /

B. Employee Information

Social Security Number	Last Name, First Name, M.I.	Primary Language Spoken

Employee Home Address	Telephone Numbers	Employee Status
Number, Street, Apt	Home ( )	☐ Active
City, State ZIP Code	Work ( )	☐ Retired

C. Plan Options - Your selection must be offered by your employer.

Check One:
☐ Indemnity Dental ☐ DentalFund/HealthFund ☐ Dental PPO ☐ Dental EPP ☐ DMO®/Advantage/Basic ☐ FOC/Indemnity ☐ FOC/PPO ☐ FOC/DMO

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. * *Provide details for "Yes" responses below.* ☐ Check this box if you are refusing coverage for your dependents.

(A)dd (C)hange (R)emove	Name (First, Middle Initial, Last) (Explain difference in last names in Special Remarks.)	Relation Code	Sex M F	Birthdate MM DD YYYY	Social Security Number (If dependent has no SSN, write "None")	Late Entrant	Prior Insur. Plan	Other Dental Coverage	Currently Covered by Medicare	Handi-capped	Student	Primary Dentist Office ID Number	Current Patient	Race/Ethnicity - *Optional* (This information is designed for the purpose of data collection and will not be used for determining eligibility, rating or claim payment.) Code	Other
						Yes	Yes *	Yes *	Yes *	Yes	Yes		Yes		
		Self	☐☐	/ /		☐	☐	☐	☐	N/A	N/A		☐		
			☐☐	/ /		☐	☐	☐	☐	☐	☐		☐		
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			☐☐	/ /		☐	☐	☐	☐	☐	☐		☐		

Using the KEY below, please identify the Race/Ethnicity code for each individual.

KEY:
01 - White
02 - African American or Black
03 - Hispanic or Latino
04 - Asian
05 - Other (Provide race/ethnicity in "Other" column at left)

1. If "Yes" to **Prior Insurance Plan** above, provide effective dates, name & policy number of insurance carrier, dental plan or other source and your **Member Identification Number.**

2. If "Yes" to **Other Dental Coverage** and/or **Currently Covered by Medicare** above, provide effective dates, name & policy number of insurance carrier, dental plan or other source and your **Member Identification Number.**

3. Does any dependent listed above live at a different address than the employee? If "Yes," who and what address? ☐ Yes ☐ No

Special Remarks

E. Employee Signature ☐ *By checking this box you agree to use Aetna Navigator, Aetna's member self-service website, for all future printed materials.*

I certify that all information supplied in this form is true and complete to the best of my knowledge and/or belief. I have read and agree to the Conditions of Enrollment on the reverse side 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 - *Required* X
Date / / E-Mail Address