

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.



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.
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Effective Date	<input type="checkbox"/> New Hire <input type="checkbox"/> Rehire/Reinstatement <input type="checkbox"/> New Group Enrollment	<input type="checkbox"/> Add Spouse/Dependent Child <input type="checkbox"/> Change of Coverage <input type="checkbox"/> Name Change <input type="checkbox"/> Other _____	<input type="checkbox"/> Employee Termination <input type="checkbox"/> Remove Spouse/Dependent Child <input type="checkbox"/> Cancel Coverage	COBRA/Cal-COBRA for: <input type="checkbox"/> Employee <input type="checkbox"/> Dependent Length of Continuation: <input type="checkbox"/> 18 <input type="checkbox"/> 36 <input type="checkbox"/> Other _____ Original Qualifying Event Date
Date of Hire	<input type="checkbox"/> Late Enrollment <input type="checkbox"/> Other _____			

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.
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1. Medical - Check one.

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

Value NetworkSM HMO:
 10/20 20/30 30/40
 40/50

Vitalidad Mexico HMO: 10

Vitalidad Plus HMO: 10/5 30/10

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: <input type="checkbox"/> Hourly \$ <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly	Primary Language Spoken (Optional)	Number of Hours Worked Per Week	Check One <input type="checkbox"/> Full-Time <input type="checkbox"/> 1099 <input type="checkbox"/> Seasonal <input type="checkbox"/> Part-Time <input type="checkbox"/> Retiree <input type="checkbox"/> 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 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow <input type="checkbox"/> Legally Separated	Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	PCP Provider Office ID Number	Current Patient <input type="checkbox"/>	Dental Office ID Number (if applicable)	Current Patient <input type="checkbox"/>
2. Name (Last, First, M.I.)					Sex (M/F)	Social Security Number		Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____
Birth date (MM/DD/YYYY)	Height (ft, in)	Weight (lbs)	Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	PCP Provider Office ID Number	Current Patient <input type="checkbox"/>	Dental Office ID Number (if applicable)		Current Patient <input type="checkbox"/>
3. Child Name (Last, First, M.I.)					Sex (M/F)	Social Security Number		Relationship <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____
Birth date (MM/DD/YYYY)	Height (ft, in)	Weight (lbs)	Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	PCP Provider Office ID Number	Current Patient <input type="checkbox"/>	Dental Office ID Number (if applicable)		Current Patient <input type="checkbox"/>
4. Child Name (Last, First, M.I.)					Sex (M/F)	Social Security Number		Relationship <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____
Birth date (MM/DD/YYYY)	Height (ft, in)	Weight (lbs)	Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	PCP Provider Office ID Number	Current Patient <input type="checkbox"/>	Dental Office ID Number (if applicable)		Current Patient <input type="checkbox"/>
5. Child Name (Last, First, M.I.)					Sex (M/F)	Social Security Number		Relationship <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____
Birth date (MM/DD/YYYY)	Height (ft, in)	Weight (lbs)	Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	PCP Provider Office ID Number	Current Patient <input type="checkbox"/>	Dental Office ID Number (if applicable)		Current Patient <input type="checkbox"/>

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
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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:**

- Certificate of Creditable Coverage from prior carrier, or
- Copy of ID card or most recent payroll stub showing medical coverage deduction, or
- 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
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> 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.

<p>1. Circulatory</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Ablation <input type="checkbox"/> Anemia <input type="checkbox"/> Aneurysm <input type="checkbox"/> Angina <input type="checkbox"/> Angioplasty <input type="checkbox"/> Blood Clot <input type="checkbox"/> TIA <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Blood Disorder	<input type="checkbox"/> Blood Vessels <input type="checkbox"/> Bypass <input type="checkbox"/> CAD <input type="checkbox"/> Chest pain <input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Disease <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Hemophilia <input type="checkbox"/> ICD Implant	<input type="checkbox"/> Palpitations <input type="checkbox"/> Phlebitis <input type="checkbox"/> Skin Ulcer <input type="checkbox"/> Stroke <input type="checkbox"/> Stent <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> High Triglycerides <input type="checkbox"/> Sickle Cell Anemia	<input type="checkbox"/> Varicose Veins <input type="checkbox"/> Tachycardia <input type="checkbox"/> Heart Valve Disorder <input type="checkbox"/> Pacemaker - Reason inserted _____ <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Irregular Heart Beat
<p>2. Intestinal</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Cirrhosis <input type="checkbox"/> Colitis <input type="checkbox"/> Crohn's <input type="checkbox"/> GERD <input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Gallbladder <input type="checkbox"/> Hernia <input type="checkbox"/> Polyp <input type="checkbox"/> Reflux <input type="checkbox"/> Pancreatitis	<input type="checkbox"/> Tumor <input type="checkbox"/> Ulcer <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Gastric Bypass/Stapling <input type="checkbox"/> Colon Disorder	<input type="checkbox"/> Colostomy: <input type="checkbox"/> Total or <input type="checkbox"/> Partial <input type="checkbox"/> Ileostomy: <input type="checkbox"/> Total or <input type="checkbox"/> Partial
<p>3. Kidney/Urinary/Bladder</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Bladder Disorder <input type="checkbox"/> Kidney Disorder <input type="checkbox"/> Polycystic Kidney <input type="checkbox"/> Prostate Disorder	<input type="checkbox"/> Kidney Stone(s) Present <input type="checkbox"/> Yes <input type="checkbox"/> No How many passed _____ Date last stone passed or surgically removed _____ <input type="checkbox"/> Dialysis - Date started _____	<input type="checkbox"/> Renal Failure <input type="checkbox"/> Polyp <input type="checkbox"/> End Stage Renal Disease	
<p>4. Respiratory</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Asthma <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe Date of last ER visit _____ <input type="checkbox"/> Injections - How often _____ <input type="checkbox"/> Allergies <input type="checkbox"/> Injections - How often _____ <input type="checkbox"/> COPD/Emphysema - On Oxygen <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Sleep Apnea: <input type="checkbox"/> CPAP or <input type="checkbox"/> BiPap <input type="checkbox"/> Chronic Bronchitis <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Lung Disorder <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polyp	<input type="checkbox"/> Sarcoidosis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Valley Fever <input type="checkbox"/> Tumor <input type="checkbox"/> Growth <input type="checkbox"/> Cyst	
<p>5. Brain</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Acoustic Neuroma <input type="checkbox"/> Alzheimer <input type="checkbox"/> Concussion <input type="checkbox"/> Paralysis <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> ALS/Lou Gehrig's Disease	<input type="checkbox"/> Brain/Head Injury Complications <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Migraines Date of last ER visit _____ <input type="checkbox"/> Cyst <input type="checkbox"/> Hemiplegia <input type="checkbox"/> Quadraplegia	<input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Tumor <input type="checkbox"/> Growth <input type="checkbox"/> Seizures/Epilepsy Date of last seizure _____ Date diagnosed _____	
<p>6. Cancer</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Basal cell <input type="checkbox"/> Bladder <input type="checkbox"/> Blood <input type="checkbox"/> Bone <input type="checkbox"/> Breast <input type="checkbox"/> Brain	<input type="checkbox"/> Cervical <input type="checkbox"/> Colon <input type="checkbox"/> Eye <input type="checkbox"/> Liver <input type="checkbox"/> Lung <input type="checkbox"/> Ovarian	<input type="checkbox"/> Prostate <input type="checkbox"/> Stomach <input type="checkbox"/> Thyroid <input type="checkbox"/> Testicular <input type="checkbox"/> Lymph System <input type="checkbox"/> Esophageal	<input type="checkbox"/> Leukemia <input type="checkbox"/> Lymphoma <input type="checkbox"/> Hodgkin's Disease <input type="checkbox"/> Melanoma <input type="checkbox"/> Metastasized <input type="checkbox"/> Squamous cell <input type="checkbox"/> Surgery <input type="checkbox"/> Chemo <input type="checkbox"/> IV Chemo <input type="checkbox"/> Radiation <input type="checkbox"/> Stage _____
<p>7. Mental Health</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Anorexia <input type="checkbox"/> Anxiety <input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Autism <input type="checkbox"/> Counseling <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Cocaine use	<input type="checkbox"/> Marijuana use <input type="checkbox"/> Opiate use <input type="checkbox"/> Heroin use <input type="checkbox"/> Methadone use	<input type="checkbox"/> Morphine use <input type="checkbox"/> Bipolar <input type="checkbox"/> Bulimia <input type="checkbox"/> Depression <input type="checkbox"/> Manic Depressive <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Suicide Attempt
<p>8. Reproductive</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Abnormal Pap <input type="checkbox"/> Breast Disorder <input type="checkbox"/> Cyst <input type="checkbox"/> Endometriosis <input type="checkbox"/> Fibroids	<input type="checkbox"/> Growth <input type="checkbox"/> Infertility <input type="checkbox"/> HPV <input type="checkbox"/> Menstrual Disorder <input type="checkbox"/> Ovarian Cysts	<input type="checkbox"/> Polycystic Ovarian Syndrome <input type="checkbox"/> Pregnant - Due date _____ <input type="checkbox"/> C section planned <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Multiples Expected (# _____) <input type="checkbox"/> Complications: <input type="checkbox"/> Present <input type="checkbox"/> Past	<input type="checkbox"/> STD <input type="checkbox"/> Tumor <input type="checkbox"/> Polyp <input type="checkbox"/> Other _____
<p>9. Transplant</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Bone <input type="checkbox"/> Bone Marrow <input type="checkbox"/> Cornea	<input type="checkbox"/> Heart <input type="checkbox"/> Heart Valve <input type="checkbox"/> Intestine	<input type="checkbox"/> Liver <input type="checkbox"/> Lung (single) <input type="checkbox"/> Lung (double)	<input type="checkbox"/> Pancreas <input type="checkbox"/> Skin <input type="checkbox"/> Stem Cell <input type="checkbox"/> Pending <input type="checkbox"/> On Waiting List <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Back/Neck Disorder <input type="checkbox"/> Breast Implants <input type="checkbox"/> Chiro adjustments <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Chronic Fatigue <input type="checkbox"/> Carpal Tunnel <input type="checkbox"/> Arthritis <input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Congenital Disorder <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Gout <input type="checkbox"/> Pins, screws, plates <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary	<input type="checkbox"/> Knee Disorder <input type="checkbox"/> Shoulder <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Amputation <input type="checkbox"/> Fracture Body part _____ Location _____	<input type="checkbox"/> Joint Replacement Location _____ <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Sprain/Strain Location _____ <input type="checkbox"/> Prosthetic Device Body part _____
	11. Endocrine/ Metabolic <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Diabetes Date diagnosed _____ <input type="checkbox"/> Diet <input type="checkbox"/> Insulin <input type="checkbox"/> Oral medication <input type="checkbox"/> Other _____	<input type="checkbox"/> Adrenal Gland <input type="checkbox"/> Gaucher's Disease <input type="checkbox"/> Goiter <input type="checkbox"/> Growth Disorder <input type="checkbox"/> Graves Disease <input type="checkbox"/> Hashimoto Disease	<input type="checkbox"/> Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> Other _____ <input type="checkbox"/> Hypothyroid <input type="checkbox"/> Hyperthyroid <input type="checkbox"/> Liver Disorder
12. Immune <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> AIDS <input type="checkbox"/> Herpes	<input type="checkbox"/> Hepatitis Exposure <input type="checkbox"/> Immune Deficiency	<input type="checkbox"/> Lupus: <input type="checkbox"/> Discoid or <input type="checkbox"/> SLE <input type="checkbox"/> Scleroderma	
13. Birth Defects/ Congenital Abnormalities <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Birthmarks <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Cleft Palate/Lip <input type="checkbox"/> Club Foot	<input type="checkbox"/> Webbed Fingers/Toes <input type="checkbox"/> Developmental Delay <input type="checkbox"/> Mental Retardation <input type="checkbox"/> Down's Syndrome	<input type="checkbox"/> Heart/Lung Malformation <input type="checkbox"/> Premature birth still receiving treatment <input type="checkbox"/> Skull/Facial or other physical deformities	
14. Eyes/Ears/ Nose/Skin <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Acne <input type="checkbox"/> Cataracts <input type="checkbox"/> Eczema	<input type="checkbox"/> Chronic Ear Infections <input type="checkbox"/> Chronic Sinusitis <input type="checkbox"/> Deviated Septum	<input type="checkbox"/> Glaucoma <input type="checkbox"/> Psoriasis <input type="checkbox"/> Retinal Disorder	<input type="checkbox"/> Burns: <input type="checkbox"/> 1st degree <input type="checkbox"/> 2nd degree <input type="checkbox"/> 3rd degree
15. Medication(s) <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Currently taking prescription medications <input type="checkbox"/> Stopped taking prescription medications within the past year			
16. Other <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Abnormal tests or physical results <input type="checkbox"/> Condition or disorder not listed above <input type="checkbox"/> Hospitalized <input type="checkbox"/> Surgery <input type="checkbox"/> Injections – what for _____ <input type="checkbox"/> Tests results pending <input type="checkbox"/> Claims in excess of \$5,000 in the past 24 months <input type="checkbox"/> Chiropractic adjustments for maintenance <input type="checkbox"/> Physical deformity or defect <input type="checkbox"/> Non ambulatory, wheel chair bound			
17. Tobacco <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Employee: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Pipe <input type="checkbox"/> Cigars <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Spouse: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Pipe <input type="checkbox"/> Cigars <input type="checkbox"/> 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.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. <input type="checkbox"/> AIDS b. <input type="checkbox"/> Diabetes c. <input type="checkbox"/> Infertility d. <input type="checkbox"/> Endocrine/Metabolic e. <input type="checkbox"/> Pancreas f. <input type="checkbox"/> Liver/Hepatitis g. <input type="checkbox"/> Immune System (other than HIV) h. <input type="checkbox"/> Blood Disorder i. <input type="checkbox"/> Epilepsy/Seizure	j. <input type="checkbox"/> Heart k. <input type="checkbox"/> Paralysis/Paresis l. <input type="checkbox"/> Tumor/Cyst/Growth m. <input type="checkbox"/> Systemic or Discoid Lupus n. <input type="checkbox"/> Lung or Respiratory o. <input type="checkbox"/> Alcohol or Drug Use p. <input type="checkbox"/> Kidney/Bladder/Urinary q. <input type="checkbox"/> Circulatory/Vascular r. <input type="checkbox"/> Digestive/Stomach/Intestinal s. <input type="checkbox"/> Central Nervous System
t. <input type="checkbox"/> Pituitary/Adrenal/Growth Disorder u. <input type="checkbox"/> Birth Defects/Congenital Abnormalities v. <input type="checkbox"/> Arthritis/Bone/Joint/Muscle/Prosthetic Device w. <input type="checkbox"/> Mental/Nervous/Emotional/Eating Disorder x. <input type="checkbox"/> Stroke/Brain/Neurological y. <input type="checkbox"/> Transplant: <input type="checkbox"/> Recommended <input type="checkbox"/> Pending <input type="checkbox"/> Complete z. <input type="checkbox"/> Advised to have surgery or course of treatment not yet determined aa. <input type="checkbox"/> Cancer: Type: _____ Stage _____ <input type="checkbox"/> Surgery <input type="checkbox"/> Chemo <input type="checkbox"/> Radiation bb. <input type="checkbox"/> Using: <input type="checkbox"/> Crutches <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair	

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

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.

<input type="checkbox"/> I AM ENROLLING FOR COVERAGE: Employee Signature X	Employee E-mail Address (optional)	Date (Month/Day/Year)
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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.

<input type="checkbox"/> Employee	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Life	Reason for declining coverage (If applicable attach front/back of your health ID card.): <input type="checkbox"/> Covered by spouse's group coverage - Carrier Name and ID number: _____ <input type="checkbox"/> Enrolled in other insurance (check applicable box): <input type="checkbox"/> Medicare <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> Military <input type="checkbox"/> Individual <input type="checkbox"/> COBRA <input type="checkbox"/> Retiree <input type="checkbox"/> Other _____ <input type="checkbox"/> Carrier Name and ID number: _____ <input type="checkbox"/> Spouse covered by employer's group coverage <input type="checkbox"/> Do Not Want
<input type="checkbox"/> Spouse	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Life	
<input type="checkbox"/> Child(ren)	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> 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). <input type="checkbox"/> I AM DECLINING COVERAGE: Employee Signature X	Date (Month/Day/Year)
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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

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-877-287-0117번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

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 Լեզվախոս Ծառայություններ: Դուք կարող եք թարգման և կարդալ ձեր փաստաթղթերը ընթերցել սույլ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) ստմնի վրա նշված կամ 1-877-287-0117 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆոռնիայի 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 مجاني 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 شناسایی 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 'ਤੇ ਸਾਨ ਫ਼ਨ ਕਰੋ। ਵਧੇਰ ਮਦਦ ਲਈ ਕੋਲੀਫੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸੂਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

សេវាកម្មភាសាឥតគិតថ្លៃ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអាស្រ័យការជំនួយអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកលើទូរស័ព្ទតាមលេខដៃសម្រាប់ 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 ntwam ua lus Hmoob. Yog xav tau kev pab, hu rau pab ntwam 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 ntwam 1-800-927-4357 Hmong