

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 2 and 3 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 5. If waiving coverage, please complete Sections B and Declination/Waiver of Coverage on Page 5 only.			
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 _____	Qualifying Event _____			

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.
1. Medical - Check one. HMO: <input type="checkbox"/> 10 <input type="checkbox"/> 15 <input type="checkbox"/> 20 <input type="checkbox"/> 30 <input type="checkbox"/> 40 <input type="checkbox"/> HRA 750 <input type="checkbox"/> HRA 1500 <input type="checkbox"/> Deductible 1000 Aetna Value NetworkSM HMO: <input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 30 <input type="checkbox"/> 40 Vitalidad Mexico HMO: <input type="checkbox"/> 5 <input type="checkbox"/> 10 EPO: <input type="checkbox"/> EPO 80 MC: <input type="checkbox"/> 250 90/70 <input type="checkbox"/> 250 80/60 <input type="checkbox"/> 500 80/60 <input type="checkbox"/> 750 80/50/50 <input type="checkbox"/> 1000 80/50/50 <input type="checkbox"/> 1000 70/50 <input type="checkbox"/> 2000 80/50/50 <input type="checkbox"/> 2500 75/50 <input type="checkbox"/> 10,000 100/50 <input type="checkbox"/> Basic <input type="checkbox"/> HRA HDHP 3000 80/50 <input type="checkbox"/> HSA HDHP 2500 80/50 <input type="checkbox"/> HSA HDHP 3000 100/50 <input type="checkbox"/> HSA HDHP 3300 80/50 PPO: <input type="checkbox"/> 500 90/70 <input type="checkbox"/> 750 80/60 <input type="checkbox"/> Aetna Indemnity <input type="checkbox"/> Out-of-State				2. Dental - Check one. (if applicable) Standard Plans: <input type="checkbox"/> 1 - DMO® Access <input type="checkbox"/> 2 - DMO® Plus (Plan 58) <input type="checkbox"/> 3 - Freedom-of-Choice Basic: <input type="checkbox"/> DMO® or <input type="checkbox"/> PPO <input type="checkbox"/> 4 - Freedom-of-Choice Plus: <input type="checkbox"/> DMO® or <input type="checkbox"/> PPO <input type="checkbox"/> 5 - PPO 1000 Active <input type="checkbox"/> 6 - PPO 1500 <input type="checkbox"/> 7 - PPO 1500 Active <input type="checkbox"/> 8 - PPO 2000 <input type="checkbox"/> Out-of-State PPO Voluntary Plans: <input type="checkbox"/> Option V1 - DMO® Access <input type="checkbox"/> Option V2 - DMO® Plus (Plan 58) <input type="checkbox"/> Option V3 - PPO 1000 Active <input type="checkbox"/> Option V4 - PPO 1500 <input type="checkbox"/> Option V5 - PPO 1500 Active <input type="checkbox"/> Out-of-State PPO Before today, were you covered under this employer's dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No				3. Life <input type="checkbox"/> Basic Life/AD&D Ultra™ <input type="checkbox"/> Optional Dependent Life <hr/> Beneficiary Designation - Full Name (First, Middle, Last) _____ Beneficiary Social Security Number _____ Relationship to Employee _____ <hr/> Whether you are enrolling or declining coverage, you must sign Page 5 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: \$	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
<input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly			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.

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"/> Widowed <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 Yes <input type="checkbox"/>	Dental Office ID Number (if applicable)	Current Patient Yes <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)	Status <input type="checkbox"/> Different Last Name	Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	PCP Provider Office ID Number	Current Patient Yes <input type="checkbox"/>	Dental Office ID Number (if applicable)	Current Patient Yes <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)	Status <input type="checkbox"/> Different Last Name <input type="checkbox"/> Lives at another address <input type="checkbox"/> Full-Time Student (19+) <input type="checkbox"/> Disabled (19+)	Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	PCP Provider Office ID Number	Current Patient Yes <input type="checkbox"/>	Dental Office ID Number (if applicable)	Current Patient Yes <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)	Status <input type="checkbox"/> Different Last Name <input type="checkbox"/> Lives at another address <input type="checkbox"/> Full-Time Student (19+) <input type="checkbox"/> Disabled (19+)	Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	PCP Provider Office ID Number	Current Patient Yes <input type="checkbox"/>	Dental Office ID Number (if applicable)	Current Patient Yes <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)	Status <input type="checkbox"/> Different Last Name <input type="checkbox"/> Lives at another address <input type="checkbox"/> Full-Time Student (19+) <input type="checkbox"/> Disabled (19+)	Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	PCP Provider Office ID Number	Current Patient Yes <input type="checkbox"/>	Dental Office ID Number (if applicable)	Current Patient Yes <input type="checkbox"/>
6. 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)	Status <input type="checkbox"/> Different Last Name <input type="checkbox"/> Lives at another address <input type="checkbox"/> Full-Time Student (19+) <input type="checkbox"/> Disabled (19+)	Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	PCP Provider Office ID Number	Current Patient Yes <input type="checkbox"/>	Dental Office ID Number (if applicable)	Current Patient Yes <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:	

If age 19+ 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 enrolling on this enrollment form have current or prior coverage? Yes No

Proof of coverage must accompany this enrollment form for pre-existing condition credit and if an employee is waiving coverage. **Acceptable forms of proof are:**

1. Certificate of Creditable Coverage from prior carrier, or
2. Copy of ID card or most recent payroll stub showing medical coverage deduction, or
3. Copy of most recent medical premium bill from prior carrier.

Failure to provide Proof of Prior Coverage may subject you or a family member 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.

Name of Covered Individual	Carrier Name	Group Number	Start Date	Termination Date	Health	Dental
					<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

G. Health Questionnaire for Groups Enrolling 2 - 10 Employees

Health History for Individuals and Their 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 the 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 listed on the enrollment form seen a health care provider(s), had treatment recommended, received treatment, including prescription medications or been hospitalized for any of the following conditions listed below?

	Yes	No
1. Heart attack, heart murmur, stroke, chest pain, high blood pressure, anemia, varicose veins or other disorders of the heart, blood (except HIV infection), blood vessels or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>
2. Ulcer, colitis, gallstones or any other disorder of the stomach, intestines, rectum, pancreas, liver or Hepatitis B or C?	<input type="checkbox"/>	<input type="checkbox"/>
3. Cancer, cyst or tumor?	<input type="checkbox"/>	<input type="checkbox"/>
Cancer: Stage, if known: _____		
4. Disorders of the kidneys, adrenal glands, thyroid gland, urinary system, male or female organs, infertility, menstrual dysfunction or sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>
5. Asthma, emphysema, tuberculosis or any other disorders of the lungs or respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>
6. Migraines, fainting spells, epilepsy, mental or nervous conditions, depression, paralysis or any disorder of the brain or nervous system? If epileptic, date of last seizure: ____ / ____ / ____ (month/day/year)	<input type="checkbox"/>	<input type="checkbox"/>
7. Lupus, arthritis, back trouble or any other disorder of the joints, muscles or bones, including prosthetic device or implants?	<input type="checkbox"/>	<input type="checkbox"/>
8. Any physical deformity, defect or congenital problem?	<input type="checkbox"/>	<input type="checkbox"/>
9. Has any person to be covered been told that they have an immune deficiency disorder (except HIV), AIDS, or AIDS-Related Complex?	<input type="checkbox"/>	<input type="checkbox"/>
10. Has any person been treated for alcoholism, other drug or substance abuse, including use of any illegal or controlled drugs, or been advised to seek treatment for the same?	<input type="checkbox"/>	<input type="checkbox"/>
11. Has any person been diagnosed with diabetes? If Yes, list date of diagnosis: ____ / ____ / ____ (month/day/year)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Insulin dependent <input type="checkbox"/> Non-insulin dependent		
12. a. Is any female to be covered currently pregnant? if Yes, list due date: ____ / ____ / ____ (month/day/year)	<input type="checkbox"/>	<input type="checkbox"/>
b. Have there been any complications thus far?	<input type="checkbox"/>	<input type="checkbox"/>
c. Are multiple births expected?	<input type="checkbox"/>	<input type="checkbox"/>
d. If you are a male listed on this enrollment form, are you expecting a child with anyone, even if the mother is not listed on this enrollment form?	<input type="checkbox"/>	<input type="checkbox"/>
13. Has any person taken any prescribed medications in the past 12 months? If Yes, list on the following page.	<input type="checkbox"/>	<input type="checkbox"/>
14. Has any person had an abnormal physical exam or been advised to undergo further testing, surgery or treatment?	<input type="checkbox"/>	<input type="checkbox"/>
15. Has any person been a patient in a hospital, clinic, surgical center, sanatorium or medical facility as an outpatient or inpatient (excluding childbirth)?	<input type="checkbox"/>	<input type="checkbox"/>
16. Does anyone named on this enrollment form use tobacco products, including cigarettes, pipe, cigars, or chewing tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, check applicable boxes. <input type="checkbox"/> Employee <input type="checkbox"/> Spouse		
17. Within the past five years has any person had any medical condition or symptom not listed on this enrollment form?	<input type="checkbox"/>	<input type="checkbox"/>

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

If you are providing additional sheets, check here and insert the sheets before sealing this Enrollment form.

H. Health Questionnaire for Groups Enrolling 11 - 50 Employees

Health History for Individuals and Their 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 the enrollment form will be returned.
- Incomplete enrollment forms may delay the effective date of your coverage.

In the past five (5) years, have you, your spouse or any of your dependents:

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Had, consulted for, had treatment rendered, been advised to have treatment or been hospitalized for any of the following: Cardiovascular disease or heart attack, stroke; disorder of the kidneys, stomach, intestines or liver; musculoskeletal conditions; mental or nervous condition; central nervous system disorder; diabetes; any disorder of the lungs or respiratory system; cancer or immune deficiency disorder (except HIV), AIDS, or AIDS-Related Complex? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you or any dependents to be covered visited a health care professional for any illness and/or medical condition resulting in medical expenses of more than \$5,000 in the past 24 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you or any dependent to be covered been advised in the last 12 months that hospitalization, surgery or treatment is needed or pending? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. a. Is any female to be covered currently pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. If you are a male listed on this enrollment form, are you expecting a child with anyone, even if the mother is not listed on this enrollment form? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Does anyone listed on this enrollment form use tobacco products, including cigarettes, pipe, cigars, or chewing tobacco? | <input type="checkbox"/> | <input type="checkbox"/> |
- If Yes, check applicable boxes. Employee Spouse

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

I. Health Questionnaire - Details for "Yes" Responses in Sections G and H.

Question Number	Name of Individual	Condition	Diagnosis Date	Date Treatment Ended	Medication Prescribed	Dosage	Still Taking Medication
							<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

If you are providing additional sheets, check here and insert the sheets before sealing this Enrollment form.

Conditions of Enrollment (continued on Page 5)

NOTICE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

On behalf of myself and the dependents listed on the reverse side, I agree to or with the following:

- I acknowledge that by enrolling in the following plans, coverage is provided by the following entities (collectively referred to as "Aetna"):
 - Aetna HMO: Aetna Health of California Inc.
 - Aetna Dental DMO: Aetna Dental of California Inc.
 - Life, Accidental Death & Dismemberment, Dental and all other health coverages: Aetna Life Insurance Company.
- I understand and agree that my employer's application will determine coverage and that there is no coverage unless and until both the eligible employee enrollment form and employer applications have been accepted and approved by Aetna. Even if this enrollment form is approved, any misstatements or omissions, **except with regards to health status related factors**, may result in future claims being denied and the policy or my coverage under the policy being reevaluated, as of the effective date, for eligibility and rating purposes. **For life coverages:** 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 benefit 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 and agree that this enrollment form may be transmitted to Aetna or its agent by my employer or its agent. I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("Providers"), including pharmacies or pharmacy database benefit managers to give to Aetna or its agent information concerning the medical history, prescription utilization history, services or treatment provided to anyone listed on this Enrollment/Change Form, including those involving mental health, substance abuse and AIDS. I further authorize Aetna to use such information and to disclose such information to affiliates, Providers, payors, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or

Conditions of Enrollment (continued from Page 4)

to conduct related activities. I have discussed the terms of this authorization with my spouse and competent adult dependents, and I have obtained their consent to those terms. I understand that this authorization is provided under state law, and that it is not an "authorization" within the meaning of the federal Health Insurance Portability and Accountability Act. This authorization is valid for term of the coverage and so long thereafter as allowed by law. I understand that I am entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original.

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.

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, NEGLIGENCELY 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.

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/կամ ընթերցել կամ փաստաթղթերը ընթերցել սույն ձեզ համար հայերեն լեզվով: Օգնության համար սեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-877-287-0117 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆոռնիայի Ասպահովագրության 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 شناسائی 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

ਮੁਫਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਬਾਰੀਏ 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 ਇਨਸ਼ੂਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

សេវាកម្មភាសាឥតគិតថ្លៃ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមាន បង្ហាញលើក្រដាសសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-877-287-0117 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រនី 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 nyem cov ntwav ua lus Hmoob. Yog xav tau kev pab, hu rau pab ntwav 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 ntwav 1-800-927-4357 Hmong