Life and Disability Enrollment/Change Request

Aetna Life Insurance Company

Effective Date	Employee Hire Date
01/01/03	

Employee Social Security Number

A. Transaction Information

1. Enrollment	Requested Employee Coverage	Requested Dependent Coverage	2. Termination (Cancel)	3. Change (*Provide explanation in Section D, Special Remarks.)
☐ New Employee ☐ Retiree ☐ Rehire/ Reinstatement ___/___/_____	☐ Basic Life ☐ AD+D/AD+PL ☐ Supplemental Life ☐ Long Term Disability ☐ Long Term Disability ☐	☐ Supplemental Dependent Life ☐ Basic Dependent Life ☐ ☐	☐ Employee* *Employee must be enrolled for dependent(s) to have coverage.	☐ Add Dependent(s) (Life Only) ☐ Remove Dependent(s) (Life Only) ☐ Plan Change ☐ Increase/Decrease Benefit Amount* ☐ Other*

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
Aquinas College	725158				

5. Employer Address (Street, City, State, ZIP Code) Location of Business or Organization	6. Claim Office Code	7. Customer Code (Optional)
1607 Robinson Rd., Grand Rapids, MI 49506		

C. Employee Information – Please Print all Information.

1. Employee Name (Last, First, Middle Initial)	2. Birthdate (MM/DD/YYYY)	3. Sex	4. Telephone Numbers
			Home ( ) Work ( )

4. Employee Home Address (Number, Street, City, State, ZIP Code)	6. Employee Annual Earnings	7. Occupation/Title	8. Work State
	$		

9. Employee Coverage Amounts – Based on the requirements of your Plan, you may have to submit evidence of good health. (Life Insurance ONLY)

Basic Life Amount	Supplemental Life Amount	Basic AD+PL/AD+D Amount	Supplemental AD+PL/AD+D Amount
$50,000	$	$50,000	$N/A

10. Beneficiary Designation (Life Insurance ONLY)
If more than one beneficiary, use Special Remarks. Dependent coverage Beneficiary is always the Employee.

Full Beneficiary Name (First, Middle, Last)	Social Security Number of Beneficiary	Relationship to Employee

D. Covered Dependents (Life Insurance ONLY)

Complete only if Dependent Coverage is offered under your Plan. ☐ **Check this box if you are refusing coverage for your dependents.**

(A)dd/New (C)hange (R)emove	Dependent Name (First, Middle Initial, Last)	Social Security Number (If dependent has no SSN, write "None")	Relat. Code	Birthdate MM/DD/YYYY	Student Age 19 or Older Yes No	Basic Dependent Amount	Supplemental Dependent Amount	Basic Dependent AD+PL/AD+D Amount	Supple-mental Dependent AD+PL/AD+D Amount
					☐ ☐	$	$	$N/A	$N/A
					☐ ☐	$	$	$N/A	$N/A
					☐ ☐	$	$	$N/A	$N/A
					☐ ☐	$	$	$N/A	$N/A
Special Remarks									

E. Certification – Signatures Required

Employee E-mail Address:

My signature below signifies my agreement with the statements and authorization under **Certification and Authorization** on the back of this form.

1. Employee Signature	Date	2. Employer Signature	Date
X ______________________________		**X** ______________________________	

Make a copy for your records.

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 the upper right corner of the form.*

*Make sure you read Section E. **Sign Name and date.***

To Enroll

- Complete **Effective Date, Employee Hire Date,** and **Employee Social Security Number** in upper right corner of form and check appropriate box(es) in **Section A**, Number **1** - *Enrollment, Requested Employee Coverage,* and *Requested Dependent Coverage.*
- Complete blank fields in **Section B - Employer Information** (if applicable).
- Complete **Section C - Employee Information**, Numbers **1** through **10**.
- Complete **Section D** for all dependents for whom you are electing coverage. Complete **ALL** items for each individual listed.

To Change

- Complete **Effective Date** and **Employee Social Security Number** in upper right corner of form and check appropriate box in **Section A**, Number **3**.
- Complete blank fields in **Section B - Employer Information** (if applicable).
- Complete **Section C - Employee Information**, Number **1**.
- Indicate change(s) in appropriate **Section(s) (B, C, D)** and *circle.*

To Terminate (Cancel)

- Complete ***Effective Date*** and ***Employee Social Security Number*** in upper right corner of form and check appropriate box in **Section A**, Number **2**.

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.

C2. **Birthdate** - Date of birth should include **four digit year of birth**.

C9. **Employee Coverage Amounts** - Consult your Benefits Administrator to identify which earnings/insurance amounts need to be reported. Complete the appropriate box and enter the rounded dollar amount.

C10. **Beneficiary Designation** - *Full Beneficiary Name (First, Middle and Last),* Social Security Number and relationship of the person to whom benefits will be paid in the event of your death.

D. Dependents Covered.

To be completed by Enrollee.

List only those individuals for whom you are electing/ changing coverage and complete ALL items for each individual listed.

- **Add/Change/Remove** - Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- **Name** - This **must** be completed for all individuals for whom you are electing or changing coverage. Please complete **ALL** items in Section **D** for each individual listed. Attach another form if you are requesting coverage for additional dependents.
- **Relationship Code** - Use **ONLY**: H=Husband, W=Wife, N=Divorced Spouse, S=Son, D=Daughter, Y=Sponsored Male, X=Sponsored Female. **If the dependent is NOT a biological or legally adopted child, please indicate relationship to employee in Special Remarks.**
- **Birthdate** - Date of birth should include **four digit year of birth**.
- **Student Age 19 or Older** - Defined as: Unmarried dependent child age 19 or older (refer to your Summary of Coverage), regularly attends school and depends solely on the enrollee for support. Member Services may request that you provide proof from the educational institution.
- **Insurance Amounts** - Consult your Benefits Administrator to identify which insurance amounts need to be reported. Complete the appropriate box(es).

E. Certification

Signatures Required.

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

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

Certification and Authorization

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 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 heath 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 Life Coverage for which I am or may become eligible and authorize deductions of the required contributions from my earnings.