



Enrollment/Change Request Aetna U.S. Healthcare®**

This application is for use by:

Aetna U.S. Healthcare of North Texas Inc. - Dallas/Fort Worth area
Aetna U.S. Healthcare Inc. - Austin/Corpus Christi/El Paso/Houston/San Antonio area

Please mail all applications to:
Aetna U.S. Healthcare**
ATTN: AUSHC Eligibility
P.O. Box 4307
Houston, TX 77210-4307

1. Plan Option (Check One)

Please read instructions on reverse side before completing this form. Print clearly.

HMO USACCESS™ MCI/QPOS® Change Plan To

Primary Co-pay: \$0 \$2 \$5 \$10 \$15 Other \$100 \$200 \$300 \$400 \$500 \$750 \$1,000 Other

2. Employee Information

Last Name, First Name, M.I. _____
Home Address _____
City, State _____ Zip Code _____
Employer Name _____
Work Address _____ Zip Code _____
Date of Hire _____

3. Type of Activity

New Subscriber Effective Date _____
 Add/Remove Spouse* Date of Event _____
 Add/Remove a Dependent Child* Date of Event _____
 Name Change From _____ To _____ Date of Event _____

6. Subscriber Primary Language (other than English)

Primer idioma del suscriptor (que no sea el Ingles)
(Call us su primer idioma?)
Do you have a disability which affects your ability to communicate or read?
 Yes No
If Yes, please indicate the nature of your disability.

7. Subscriber Disability

What is your primary language?
(Call us su primer idioma?)
Do you have a disability which affects your ability to communicate or read?
 Yes No
If Yes, please indicate the nature of your disability.

4.	No.	Add	Remove	Last Name, First Name, M.I.	Sex M F	Date of Birth MM DD YYYY	Social Security Number	5. Change	Primary Office Number	Current Patient	OB/GYN Office Number (Not required) (Read Notice on Back)	Dentist Office Number (if applicable)	Current Patient
Employee	a.	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	/ /		<input type="checkbox"/>		<input type="checkbox"/>			<input type="checkbox"/>
Spouse	b.	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	/ /		<input type="checkbox"/>		<input type="checkbox"/>			<input type="checkbox"/>
Children	c.	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	/ /		<input type="checkbox"/>		<input type="checkbox"/>			<input type="checkbox"/>
* Attach sheet to list additional children	d.	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	/ /		<input type="checkbox"/>		<input type="checkbox"/>			<input type="checkbox"/>
* Attach proof if full-time college student	e.	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	/ /		<input type="checkbox"/>		<input type="checkbox"/>			<input type="checkbox"/>
	f.	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	/ /		<input type="checkbox"/>		<input type="checkbox"/>			<input type="checkbox"/>

8. Other Insurance

Is your Spouse Employee? Yes No
If Yes, please give name and address of spouse's employer.

9. Dependent Information

Do any of the dependents listed in Section 4 live at another address? Yes No
If Yes, who and at what address?
Explain the circumstances.
If any dependent's last name is different from yours, explain the circumstances.

10. Withdrawal From Plan

No Longer in Group Date of Withdrawal _____
 Individual Conversion - Bill me at Home I Decline Nongroup Coverage
Note: For COBRA information - See your employer
limited to prescription drug and dental.)

11. Employer Verification

Signature _____ Title _____ Date _____

12. Employee Signature

If you have any questions concerning the benefits and services that are provided by or excluded under this Agreement, please contact a Member Services representative at 1-800-323-9930 before signing this form.
Subscriber _____ Date _____
E-mail Address _____
Employee copy may be used as a temporary ID card for 30 days from the effective date if authorized by employer. Coverage must be verified with Aetna U.S. Healthcare** prior to visiting a specialist or admission to a hospital.

AETNA U.S. HEALTHCARE

**Also doing business as Aetna U.S. Healthcare Inc.; Aetna U.S. Healthcare of North Texas, Inc.

Enrollment/Change Request Instructions

To Enroll: Complete all sections, except Section 10

To Make Changes: For all changes - complete Sections 2, 3, 11 and 12. Depending on the Type of Activity box(es) selected, complete the corresponding applicable sections.

A Withdrawal/Termination also requires completion of Section 10.

Attention Female Members: Your choice of a PCP affects your choice of an OB/GYN. In selecting your PCP, remember that your PCP's network affects your choice of an OB/GYN. You have the right to receive services from an OB/GYN without first obtaining a referral from your PCP. However, the OB/GYN from whom you receive services must belong to the same network as your PCP. This is another reason to make certain that our PCP's network includes the specialists - particularly the OB/GYN - and hospitals that you prefer. You are not required to designate an OB/GYN. You may elect to receive your OB/GYN services from your PCP.

Section 1 Check one Plan Option box, indicate Plan Option Name (where applicable) and check one Primary Co-pay and/or Individual Deductible Amount (if applicable).	Section 5 From the appropriate provider directory, locate the office number for the primary care physician and/or dentist (if applicable). Indicate office number selection(s) on form. Check the change block only if you are a current member and are changing providers.
Section 2 Complete all information in order for your application to be processed.	Sections 6, 7, 8 & 9 Complete these sections for all new enrollments or coverage changes (if applicable).
Section 3 Check box(es) indicating reason(s) for submitting form. Provide Effective Date/Date of Event and Reason (where requested).	Section 10 Complete this section only if Withdrawing/Terminating from the plan.
Section 4 Print your full name along with the name(s) of your dependent(s), if applicable. Indicate Sex, Date of Birth, and Social Security Number for each individual listed. If a dependent is a full-time college student, you must attach a current course schedule or a letter from the school confirming full-time student status (as determined by the school). To indicate whether you are Adding or Removing self and/or dependents, check the appropriate Add or Remove boxes.	Sections 11 & 12 Complete these sections for all new enrollments or coverage changes. Employer and Employer must sign and date the application in order for it to be processed.

Conditions of Enrollment

Applicant Acknowledgments and Agreements

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

1. Enrollment of yourself and of the listed dependents into the plan shall be effective on acceptance by Aetna U.S. Healthcare**.
2. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. Your employer is hereby authorized to withhold premium payments from your wages as appropriate.
3. As a condition of coverage, you understand and agree that (with the exception of emergency procedures and certain direct access services as defined in the plan documents) all services, in order to be covered by the Aetna U.S. Healthcare**, must be performed either by a participating primary care physician or by the participating specialist, hospital, pharmacy, dentist, or other provider as authorized by a prior referral from a participating physician***.
4. You agree to make copayments, as provided for in your plan documents, directly to providers of health care.
5. Aetna U.S. Healthcare** (including its affiliates and agents, collectively "Aetna U.S. Healthcare") and participating network providers require access to member medical information for a number of purposes, including claims payment and fraud prevention; preventive health, early detection and disease management programs; coordination of patient care; quality improvement/management/assessment; utilization review and management; fulfilling state and federal requirements; HEDIS and similar data collection and reporting; accreditation by the National Committee for Quality Assurance and other accreditation organizations; and statistical research. Accordingly, you authorize the sharing of member medical information about yourself and your listed dependents between Aetna U.S. Healthcare** and any hospital, physician, or other health care provider or health delivery system as Aetna U.S. Healthcare** and such participating network providers may require. Please be assured that it is Aetna U.S. Healthcare's** policy to protect the confidential medical information to the full extent required by the law. I know that I, or an individual entitled to act on my behalf, am entitled to receive a copy of this authorization upon request and agree that a photocopy is as valid as the original.
6. 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 HMO plan.
7. You understand that this coverage will remain in effect until your employer's next open-enrollment period regardless of the continued availability of a particular primary care physician or other health care provider.
8. You acknowledge that Aetna U.S. Healthcare's** participating providers, including all participating primary care physicians, are independent contractors and are neither agents nor employees of Aetna U.S. Healthcare**.

Your enrollment in Aetna U.S. Healthcare and accessing of your benefits signifies your agreement to these conditions, which are subject to change.

*** Some services may require prior authorization from Aetna U.S. Healthcare.

Misrepresentation

9. Any person who knowingly and with intent to injure, defraud or deceive 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.

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