

Health Insurance Only



Enrollment/Change Request

Aetna U.S. Healthcare®

Please read instructions on reverse side before completing this form.

Group Name
Jimco Maintenance Inc.

Group Number
189370

Aetna U.S. Healthcare ID No.

1. Plan Option (Check One) *Print clearly.*

HMO (Please Indicate Plan Name) USAccess® QPOS® (Please Indicate Plan Name)

Primary Co-pay: \$0 \$2 \$5 \$10 \$15 Other **\$35.00**

Individual Deductible Amount: \$100 \$200 \$250 \$300 \$400 \$500 \$750 \$1,000 Other _____

2. Employee Information

| | | | |
|---|----------|--------------------------------------|--------------|
| Last Name, First Name, M.I. | | Social Security Number | |
| Home Address | | Apartment Number | |
| City, State | Zip Code | Home Telephone () | |
| Employer Name Jimco Maintenance Inc. | | Work Telephone (941) 485-5985 | |
| Work Address 710 Commerce Drive #107, Venice, FL | | Zip Code 34292 | Date of Hire |

3. Type of Activity

New Subscriber Effective Date _____ Change Plan To _____ Date of Event _____

Add/Remove Spouse* Reason _____ Date of Event _____ Add/Change Primary Office* Add/Change Primary Dentist*

Add/Remove a Dependent Child* Reason _____ Date of Event _____ Withdrawal/Termination (Complete Section 8 Below)

Name Change From _____ To _____ * **Complete Sections 4 & 5 Below** Date of Event _____

| 4. | No. | Add | Remove | Last Name, First Name, M.I. | Sex M F | Date of Birth MM DD YYYY | Social Security No. |
|---|-----|--------------------------|--------------------------|-----------------------------|---|-----------------------------|---------------------|
| Employee | a. | <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"/> | / / | |
| Children | c. | <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"/> | / / | |
| * Attach proof if full-time college student | e. | <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"/> | / / | |

| 5. | Change | Primary Office No. | Weekly Payroll deduction |
|----|--------------------------|--------------------|-------------------------------|
| a. | <input type="checkbox"/> | | \$15.00/week |
| b. | <input type="checkbox"/> | | \$75.90/week |
| c. | <input type="checkbox"/> | | \$56.82/week |
| d. | <input type="checkbox"/> | | \$124.65/week Family Coverage |
| e. | <input type="checkbox"/> | | |
| f. | <input type="checkbox"/> | | |

6. Other Insurance

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

Does your spouse have health insurance? Yes No If Yes, please give name and policy number of insurance carrier or other HMO.

If Yes, who is covered by this policy?
 Yourself Yourself/Spouse Spouse Only Entire Family

7. 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.

8. 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. (prescription and dental benefits are not convertible)

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.

X **9. Employee Signature**

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the reverse side of the employee copy of this application. **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.

10. Employer Verification

| | | |
|-----------|-------|------|
| Signature | Title | Date |
|-----------|-------|------|

Enrollment/Change Request Instructions

To Enroll: Complete all sections, except Section 8

To Make Changes: For all changes - complete Sections 2, 3, 9 and 10. Depending on the Type of Activity box(es) selected, complete the corresponding applicable sections. A Withdrawal/Termination also requires completion of Section 8.

| | |
|------------------|--|
| 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 2 | Complete all information in order for your application to be processed. |
| Section 3 | Check box(es) indicating reason(s) for submitting form. Provide Effective Date/Date of Event and Reason (where requested). |
| 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 (12 or more credits). To indicate whether you are Adding or Removing self and/or dependents, check the appropriate Add or Remove boxes. |

Conditions of Enrollment

| | |
|---|--|
| Applicant Acknowledgments and Agreements | <p>On behalf of myself and the dependents listed on the reverse side, I agree to the following:</p> <ol style="list-style-type: none"> 1. Enrollment of yourself and of the listed dependents into the plan is 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 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 pharmacy, dentist, or other provider as authorized by a referral from a participating primary care 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 authorized 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 providers may require. Please be assured that it is Aetna U.S. Healthcare's policy to protect the confidentiality of your 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 authorize the substitution of generic pharmaceuticals for the brand-name products, as provided by law, for prescriptions filled under any pharmacy benefit rider. 8. 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. 9. 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. |
| Misrepresentation | <p>10. Any person who knowingly and with intent to injure, 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.</p> <p>* Some services may require prior authorization from Aetna U.S. Healthcare.</p> |

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