Aetna Dental

PPI Benefit Solutions
ACSA Group Insurance Trust

Oyster Bay East Norwich Central School District

ENROLLMENT/CHANGE
REQUEST FORM
Employer No. 026820

Mailing Address:
245 Long Hill Road
Middletown, CT 06457
Phone: (888) 674-0046
Fax: (860) 343-4963

Section 1 – Plan Options

Aetna Dental Freedom of Choice ☐ **DMO** ☐ **PPO**

NOTE: After the initial election, the employee must call Aetna directly at the toll free number on their ID card to switch between the DMO and PPO plans. This type of plan change cannot be processed by PPI or on AutoEnroll.

Section 2 – Type of Activity

*Employer ***must*** complete *both* of the following if enrolling or changing coverage:
***Date of Hire or Rehire:** __ __ - __ __ - __ __ __ __
***Effective Date of Coverage:** __ __ - __ __ - __ __ __ __

1. ENROLL FOR COVERAGE (List all enrollees in Section 3):
☑ New/Rehire
☐ Open Enrollment
☐ Part-time to Full-time status
☐ Loss of other coverage (HIPAA Cert from prior carrier required)
Date of Loss of Coverage: __________

2. CHANGES TO COVERAGE
A. Add Dependents (List Deps in Section 3):
☐ Birth/Adoption
☐ Marriage
☐ Other **(specify):**__________
Date of Event: __________

PLEASE NOTE THE FOLLOWING:
Provider Changes after your initial election must be reported directly to the insurance carrier.

B. Other Changes (Specify on form)
☐ Open Enrollment Plan Change
☐ Name Change
☐ Address Change
☐ Beneficiary Change

3. REMOVE COVERAGE
A. Cancel Dependents (List Deps in Section 3):
☐ Loss of Student Status
☐ Divorce/Separation
☐ Gained Other Coverage
☐ Death
☐ Other **(specify):**__________
Date of Loss: __________

B. Term Employee Coverage
☐ Reduced Hours
☐ Gained Other Coverage
☐ Retirement
☐ Other **(specify):**__________
Date of Loss: __________

To *Terminate ALL employee coverage*, please use PPI's *Employer Change Report*.

Section 3 – Individuals Covered (A=Add C=Change R=Remove)

EMPLOYEE:

Last Name	First Name	SS# ___ — __ — ____	
Home Address	City	State	Zip
Date of Birth __ / __ / ____	Gender: ☐ M ☐ F	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other	
Dental: ☐ A ☐ C ☐ R	Provider ID# (if DMO checked in Section 1):		Existing Patient: Yes ☐ No ☐

SPOUSE:

Last Name	First Name	SS# ___ — __ — ____	
Date of Birth __ / __ / ____	Gender: ☐ M ☐ F		
Dental: ☐ A ☐ C ☐ R	Provider ID# (if DMO checked in Section 1):		Existing Patient: Yes ☐ No ☐

CHILD:

Last Name	First Name	SS# ___ — __ — ____	
Date of Birth __ / __ / ____	Gender: ☐ M ☐ F		
Full-time Student? ☐ No ☐ Yes (Complete Section 4)	Handicapped Child? ☐ No ☐ Yes (Separate form may need to be completed)		
Dental: ☐ A ☐ C ☐ R	Provider ID# (if DMO checked in Section 1):		Existing Patient: Yes ☐ No ☐

CHILD:

Last Name	First Name	SS# ___ — __ — ____	
Date of Birth __ / __ / ____	Gender: ☐ M ☐ F		
Full-time Student? ☐ No ☐ Yes (Complete Section 4)	Handicapped Child? ☐ No ☐ Yes (Separate form may need to be completed)		
Dental: ☐ A ☐ C ☐ R	Provider ID# (if DMO checked in Section 1):		Existing Patient: Yes ☐ No ☐

CHILD:

Last Name	First Name	SS# ___ — __ — ____	
Date of Birth __ / __ / ____	Gender: ☐ M ☐ F		
Full-time Student? ☐ No ☐ Yes (Complete Section 4)	Handicapped Child? ☐ No ☐ Yes (Separate form may need to be completed)		
Dental: ☐ A ☐ C ☐ R	Provider ID# (if DMO checked in Section 1):		Existing Patient: Yes ☐ No ☐

Please use a separate sheet of paper for additional dependents.

Please continue on the reverse side

Section 4 – Student Status Information

Generally, dependents over the age of 18 must be full-time students to be eligible for coverage. Please list below all full-time students from Section 3 and include the name of the school and the student's expected date of graduation. Use a separate sheet of paper for additional students.

Dependent Name: _____	Dependent Name: _____
Name of School: _____	Name of School: _____
Expected Graduation Date: _____	Expected Graduation Date: _____

Section 5 – Waiver of Coverage (Complete and sign *ONLY* if waiving coverage(s) for yourself and/or your dependents)

I hereby certify that I have been given an opportunity to enroll for Group Health Insurance benefits offered by my employer and have decided **NOT** to enroll in the following coverage(s):

☐ Dental ☐ Dependent Dental

I understand that if I delay enrolling more than 31 days after the date I could first become insured, the dental benefits for myself and my dependents may be limited for a period time as determined by the plan rules.

_____ ____/____/____
Employee's Signature Date

Section 6 – Employee Signature

I represent that all the information supplied in this application is true and complete. I have personally designated the beneficiaries shown on this form (if applicable) and hereby request group insurance for myself and for my dependents listed on this form for selected coverages noted in Section 1. I hereby authorize my employer or successor to make deductions from my earnings of the required contributions, if any, to apply toward the insurance costs for the insurance provided for in the policy of group insurance issued to my employer.

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 Plan. Further, I understand that any insurance subject to evidence of good health or medical information will not become effective until the carrier 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 the carrier does not receive notice of the Enrollment/Change Request within a reasonable time following the event, my eligibility and my dependent's eligibility may be affected.

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.

_____ ____/____/____
Employee's Signature Date

Section 7 – Employer Verification

Employer's Signature	Title	Date

IMPORTANT Before signing this form, please review it for accuracy and completeness. Incomplete forms will be held pending for missing information resulting in a delay in processing. Should you need assistance, please contact PPI's account service team at (888) 674-0046.