

Election Form

Complete this form and make a copy for yourself. Give the original to your employer.

IF YOU ARE NOT CHANGING YOUR EXISTING COVERAGE, YOU DO NOT NEED TO COMPLETE THIS FORM.

A. INFORMATION ABOUT YOU

Print Your Name (First, Middle Initial, Last)

Mailing Address _____ City _____ State _____ Zip Code _____

Home Phone () _____ Date of Birth (MM/DD/YYYY) _____ Social Security Number _____

B. YOUR ELECTION

(Check the appropriate box.)

I am not currently enrolled and I elect to....

- Enroll** in the coverage Option(s) selected below. ❶
- Decline** this opportunity to participate.

I am currently enrolled and I elect to....

- Change** my current coverage with the Option(s) selected below. ❶
- Change** my personal, dependent, and/or beneficiary information.
- Drop** all of my current coverage Option(s).

❶ By selecting the coverage Option(s) below, I authorize my employer to deduct from my paycheck, any required contributions.

Your Signature _____ Today's Date (MM/DD/YYYY) _____

C. YOUR COVERAGE OPTIONS

For each coverage you wish to adjust: 1) Check the appropriate box (☐) for the action you wish to make (add/drop/change to); and 2) Check the appropriate box (☐) for whom this action applies.

MEDICAL You may elect either Option 1 or Option 2.	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Change To	(List Dependents on the back of this form)	Monthly Cost
		Option 1 <input type="checkbox"/> Yourself Only \$ 62.40 <input type="checkbox"/> Yourself Plus One..... \$155.32 <input type="checkbox"/> Yourself and Family..... \$222.20 Option 2 <input type="checkbox"/> Yourself Only \$ 80.92 <input type="checkbox"/> Yourself Plus One..... \$201.96 <input type="checkbox"/> Yourself and Family..... \$289.08	
HOSPITAL INDEMNITY	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Change To	(List Dependents on the back of this form)	Monthly Cost
		<input type="checkbox"/> Yourself Only \$ 14.96 <input type="checkbox"/> Yourself Plus One..... \$ 29.92 <input type="checkbox"/> Yourself and Family..... \$ 44.88	
VISION CARE	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Change To	(List Dependents on the back of this form)	Monthly Cost
		<input type="checkbox"/> Yourself Only \$ 4.36 <input type="checkbox"/> Yourself Plus One..... \$ 7.40 <input type="checkbox"/> Yourself and Family..... \$ 10.40	
DENTAL	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Change To	(List Dependents on the back of this form)	Monthly Cost
		<input type="checkbox"/> Yourself Only \$ 19.28 <input type="checkbox"/> Yourself Plus One..... \$ 38.60 <input type="checkbox"/> Yourself and Family..... \$ 63.72	
SHORT TERM DISABILITY	<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Yourself Only ❷ \$ 15.20 ❷ Not available in California, Hawaii, New Jersey, New York, Rhode Island, and Puerto Rico.	Monthly Cost
TERM LIFE INSURANCE	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Change To	(List Beneficiary and Dependents on the back of this form)	Monthly Cost
		<input type="checkbox"/> Yourself Only \$ 6.68 <input type="checkbox"/> Yourself and Family..... \$ 8.16	

FOR YOUR EMPLOYER'S USE ONLY

Employee ID: _____ Hire Date (MM/DD/YYYY): _____ Pay Type: _____ Total Deduction: \$ _____
 Location or Site Code: _____ Authorized Signature: _____ Today's Date (MM/DD/YYYY): _____



D. BENEFICIARY INFORMATION

Print Beneficiary's Name (First, Middle Initial, Last)

Relationship

Social Security Number

E. DEPENDENT INFORMATION

Check here if you have more dependents and provide all requested information on a separate sheet and attach it to this form.

<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Change To	Print Dependent's Name (First, Middle Initial, Last)		Social Security Number		
	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship	Date of Birth		
	If over 18, is your child: <input type="checkbox"/> Full-time student? <input type="checkbox"/> Disabled?	Enrolled in the following coverage(s): <input type="checkbox"/> Medical <input type="checkbox"/> Hospital Indemnity <input type="checkbox"/> Vision Care <input type="checkbox"/> Dental <input type="checkbox"/> Term Life			
	If this dependent has a different address than you, list it here:	Street Address	City	State	Zip Code

<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Change To	Print Dependent's Name (First, Middle Initial, Last)		Social Security Number		
	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship	Date of Birth		
	If over 18, is your child: <input type="checkbox"/> Full-time student? <input type="checkbox"/> Disabled?	Enrolled in the following coverage(s): <input type="checkbox"/> Medical <input type="checkbox"/> Hospital Indemnity <input type="checkbox"/> Vision Care <input type="checkbox"/> Dental <input type="checkbox"/> Term Life			
	If this dependent has a different address than you, list it here:	Street Address	City	State	Zip Code

<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Change To	Print Dependent's Name (First, Middle Initial, Last)		Social Security Number		
	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship	Date of Birth		
	If over 18, is your child: <input type="checkbox"/> Full-time student? <input type="checkbox"/> Disabled?	Enrolled in the following coverage(s): <input type="checkbox"/> Medical <input type="checkbox"/> Hospital Indemnity <input type="checkbox"/> Vision Care <input type="checkbox"/> Dental <input type="checkbox"/> Term Life			
	If this dependent has a different address than you, list it here:	Street Address	City	State	Zip Code

<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Change To	Print Dependent's Name (First, Middle Initial, Last)		Social Security Number		
	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship	Date of Birth		
	If over 18, is your child: <input type="checkbox"/> Full-time student? <input type="checkbox"/> Disabled?	Enrolled in the following coverage(s): <input type="checkbox"/> Medical <input type="checkbox"/> Hospital Indemnity <input type="checkbox"/> Vision Care <input type="checkbox"/> Dental <input type="checkbox"/> Term Life			
	If this dependent has a different address than you, list it here:	Street Address	City	State	Zip Code

QUALIFYING LIFE EVENTS

A. LOSS OF OTHER COVERAGE (LOC): If you previously declined health coverage because you or your dependents were already covered under another health plan and you or your dependents have lost that other coverage, you may be allowed to enroll yourself and your dependents. You must submit this form, together with documentation, to your employer within 31 days of the LOC. If you are entitled to this special enrollment, complete **sections A & B** (on the front) then go to the list on the right and check the box next to your LOC, supply the date of the LOC, and finish completing the form through **section E**. When finished, make a copy of this form and give it to your employer with your documentation attached.

Check the box of the description that identifies your **LOC**.

- Divorce, legal separation or death
- Termination of employment of a dependent
- Reduction of a dependent's hours
- Termination of your or your dependents' COBRA rights
- Loss of employer's contribution to spouse's coverage
- Dependent child losing eligibility as a dependent
- Other loss of coverage

Date of the LOC:

B. FAMILY STATUS CHANGES (FSC): Whether you are currently enrolled or previously declined coverage, you may be allowed to add, increase, decrease or drop coverage when you experience certain FSC events. You must submit this form, together with documentation, to your employer within 31 days of the FSC. If you are so entitled because of a recent FSC, complete **sections A & B** (on the front) then go to the list on the right and check the box next to your FSC, supply the date of the FSC, and finish completing this form through **section E**. When finished, make a copy of this form and give it to your employer with your documentation attached.

Check the box of the description that identifies your **FSC**.

- Divorce, legal separation or death
- Marriage
- Birth or adoption of a dependent
- Other

Date of the FSC:



Record keeping by Strategic Resource Company (SRC).
Insurance plans are underwritten by Aetna Life Insurance Company.
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