HEALTH BENEFITS ENROLLMENTFORM

Employee Information

Last Name, First Name		Social Security Number	Plan Options Medical Plan (check one only) AETNA HMO ☐ (IN CA ONLY) AETNA POS ☐ AETNA BASIC PPO ☐ Dental Plan (check one only) AETNA DMO ☐ AETNA PPO ☐ Vision Service Plan ☐
Address (street, city, state, zip)		Date of Birth	
Cell Phone	Office Phone	Personal Email	

List YOUR name and eligible dependents below (check MEDICAL/DENTAL/VISION boxes for coverage)
Marriage certificate required to add spouse and birth certificate(s) required to add children (unless previously provided)

Last Name , First Name	SSN	DOB	Sex M/F	Relation to Employee	MEDICAL	For HMO only CA only Doctor #[1]	Current Y/N	DENTAL	For DMO only Dentist #[1]	Current Y/N	VISION
				SELF	☐			☐			☐
					☐			☐			☐
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Submit this form along with required back-up documentation within 30 days from your eligibility date via the SECURE WEB LINK FOR EMPLOYEE FORMS posted on the benefits website (drag and drop). Faxes & scans to emails will not be accepted.
Need help? Call Benefits (818) 331-1041 / (818) 972-0787

EMPLOYEE AUTHORIZATION (Required)

I hereby authorize the transactions indicated on this form, including payroll deductions, if any, on a pre-tax basis for the coverage I elect. I further state that I understand that the election(s) I make cannot be changed until the next Open Enrollment period or within 30 days of a qualified change in status or other circumstances as defined by the Internal Revenue Code. I further state that all information furnished is true and complete to the best of my knowledge and I authorize the carrier or agent to obtain medical records and information from providers relating to me and my eligible dependents, to the extent required to provide administrative services in connection with the plans.

Employee Signature _____ **Date**

Date of Hire	Eligibility Date	Production

For office use only

[1] Use Provider Search at www.aetna.com to find Primary Medical/Dental Office IDs