GMA+
General McLane School District

AETNA Medical Benefit Enrollment / Change Form/Waiver

☐ NEW ENROLLMENT ☐ CHANGE ☐ WAIVE: (please complete Subscriber Info & sign waiver)

Enrollment:	Change - (check all that apply)	Remove or Terminate:
☐ New Enrollee/Subscriber	☐ Add Spouse Date of Event	☐ Remove Spouse
☐ Rehire/Reinstatement	☐ Add Dependent Child(ren) __/__/____	☐ Remove Dependent Child(ren)
Date of Hire/Rehire: ____/____/______	☐ Name Change Event Reason:__________	Reason:

☐ AETNA Choice POS II Group: PPO #0210091	Employee #001 ☐ COBRA #101 ☐ Retiree #102 ☐	Effective Date ____/____/______

SUBSCRIBER INFORMATION:

Type of Coverage: Individual ☐ Employee/Spouse ☐ Employee/Children ☐ Family ☐

*Last Name	*First Name	*MI	*Social Security Number	*Birthdate	*Gendor
			- -	__/__/____	Male ☐ Female ☐

*Street Address	*City	*State	*Zip	*Phone	*E-Mail

FAMILY MEMBERS TO BE COVERED OR DELETED: The Federal Patient Protection & Affordable Care Act mandates coverage of dependent children up to age 26.

	*Last Name	*First Name	*MI	*Social Security #	*Birthdate	*Gendor	*Relationship
Add ☐ Delete ☐				- -	__/__/__	Male ☐ Female ☐	Spouse ☐ Child ☐ Other:
Add ☐ Delete ☐				- -	__/__/__	Male ☐ Female ☐	Spouse ☐ Child ☐ Other:
Add ☐ Delete ☐				- -	__/__/__	Male ☐ Female ☐	Spouse ☐ Child ☐ Other:
Add ☐ Delete ☐				- -	__/__/__	Male ☐ Female ☐	Spouse ☐ Child ☐ Other:
Add ☐ Delete ☐				- -	__/__/__	Male ☐ Female ☐	Spouse ☐ Child ☐ Other:
Add ☐ Delete ☐				- -	__/__/__	Male ☐ Female ☐	Spouse ☐ Child ☐ Other:
Add ☐ Delete ☐				- -	__/__/__	Male ☐ Female ☐	Spouse ☐ Child ☐ Other:

OTHER MEDICAL COVERAGE INFORMATION:

*Other Insurance Company Name	*Policy Holder Name	*Covered Dependents

Authorization signature on reverse ——>

WAIVER: My employer has given me an opportunity to apply for group heath coverage for myself and my dependents (if applicable)

I do not elect to enroll in the group health coverage at this time for: ☐ Myself ☐ Spouse ☐ Dependents

Reason for decline: ☐ Other health insurance ☐ Spousal coverage ☐ Other reason (please explain)

I understand that if I waive enrollment in the plan and wish to enroll at a later date, I may not be able to do so until the next open enrollment (July 1st), unless I have a change in status qualifying event.

Changes in status include: Marriage, divorce, birth or adoption of a child, termination of spousal coverage, change from Full-time to Part-time, or Unpaid Leave of Absence .

Employee Signature (only if you are waiving coverage) **Date:**

AGREEMENT AND AUTHORIZATION Please read the following carefully

I certify that all information supplied on this form is correct and true to the best of my knowledge. I further authorize my employer to deduct from my earnings the contribution required to apply toward the cost of this plan.

I have read and agree to the statement above. (Signature Required Below)

Applicant Signature **E-Mail Address** **Date:**

Authorization signature on reverse ---->