

# Domestic Choctaw Enterprise Benefits Enrollment/Change Form



**This Section is for Office Use Only:**

Employee ID:	Date of Hire:	BU #:	Branch Code:
Effective Date:	Dept:	Company Code:	Aetna Account: 819977

**Please check the following:**

<b>Enrollment:</b>	<input type="checkbox"/> New Employee	<input type="checkbox"/> Retired/Reinstatement	<input type="checkbox"/> Annual Enrollment
<b>Change:</b>	<input type="checkbox"/> New Employee	<input type="checkbox"/> Add/Remove Dependent (List names in Section 2)	<input type="checkbox"/> Change Address <input type="checkbox"/> Other _____
<b>Status Change Event:</b>	<input type="checkbox"/> Marriage	<input type="checkbox"/> Divorce	<input type="checkbox"/> Birth <input type="checkbox"/> Death <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Separation/Reduction In Hours <input type="checkbox"/> Adoption/Adoptive Placement

**Section 1-Employee Information (Please Print Above Lines.)**

Last Name	First	Middle	Social Security Number
Mailing Address		City	State
			Zip Code <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Phone Number	Work Phone Number	Date of Birth (MM/DD/YY)	Gender (Check)

**Section 2-Dependent Information- Please send proof of legal dependency for dependants with a last name that is different from the last name of the employee. Please list additional dependants on another sheet.**

<input type="checkbox"/> Add <input type="checkbox"/> Drop	Last Name	First	MI	Birth Date (MM/DD/YY)	SS#	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	F/T Student: YES or NO Disabled: YES or NO Does Dependent reside with you? YES or NO Other Medical Coverage: YES or NO <b>Relationship to You:</b>
<input type="checkbox"/> Add <input type="checkbox"/> Drop	Last Name	First	MI	Birth Date (MM/DD/YY)	SS#	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	F/T Student: YES or NO Disabled: YES or NO Does Dependent reside with you? YES or NO Other Medical Coverage: YES or NO <b>Relationship to You:</b>
<input type="checkbox"/> Add <input type="checkbox"/> Drop	Last Name	First	MI	Birth Date (MM/DD/YY)	SS#	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	F/T Student: YES or NO Disabled: YES or NO Does Dependent reside with you? YES or NO Other Medical Coverage: YES or NO <b>Relationship to You:</b>
<input type="checkbox"/> Add <input type="checkbox"/> Drop	Last Name	First	MI	Birth Date (MM/DD/YY)	SS#	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	F/T Student: YES or NO Disabled: YES or NO Does Dependent reside with you? YES or NO Other Medical Coverage: YES or NO <b>Relationship to You:</b>
<input type="checkbox"/> Add <input type="checkbox"/> Drop	Last Name	First	MI	Birth Date (MM/DD/YY)	SS#	Gender	F/T Student: YES or NO Disabled: YES or NO Does Dependent reside with you? YES or NO Other Medical Coverage: YES or NO <b>Relationship to You:</b>
	Last Name	First	MI	Birth Date (MM/DD/YY)	SS#	Gender	

If you answered YES to "Full Time Student" or "Disabled" for any dependants, provide documentation of disability or proof of full time student status. (F/T Student is defined as 19 to 24 years old, attending an accredited secondary school).

**Section 3- Please check your selections. If you are a SCA employee, you have to elect medical/vision and dental, coverage and do not have the option to opt out.**

Election	Coverage Levels
<p><b>*Medical/Vision Coverage</b> Administered by: Aetna Account #:819977</p> <p><input type="checkbox"/> Elect Medical Coverage <input type="checkbox"/> Waive Medical Coverage</p>	<p><input type="checkbox"/> Employee only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child (ren) <input type="checkbox"/> Employee + Family</p>
<p><b>*Dental Coverage</b> Administered by: Aetna Account # 819977</p> <p><input type="checkbox"/> Elect Dental Coverage <input type="checkbox"/> Waive Dental Coverage</p>	<p><input type="checkbox"/> Employee only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child (ren) <input type="checkbox"/> Employee + Family</p>

**Section 4**

**\* Basic Life & AD&D Insurance**      **Choctaw provides Life and AD&D benefits at no cost to you. Enrollment is not required, however salary information is required. Please provide your Annual Salary.**  
**Administered By: Aetna**      **Salary: \$ \_\_\_\_\_**

**\*Beneficiary Designation**      You must name a primary beneficiary to receive your Basic Life Insurance or Basic AD&D in the event of your death. If your primary and contingent beneficiaries are not living at the time of your death or this designation is not properly completed, the terms of the plan will determine to whom your distribution belongs. This form revokes any previous designations of primary beneficiary (ies) and contingent beneficiary (ies) (if any).

**Primary Beneficiary**

Name	Social Security Number	Date of Birth	%Percentage	
Relationship to You	Address	City	State	Zip

**Contingency**

Name	Social Security Number	Date of Birth	%Percentage	
Relationship to You	Address	City	State	Zip

Name	Social Security Number	Date of Birth	%Percentage	
Relationship to You	Address	City	State	Zip

**Section 5**

**PROVISIONS & SIGNATURE**

**Authorization to Disclose Confidential Information and Fraud Notice**

I understand that coverage is being provided by the following companies: Traditional Choice®, Open Choice® and Managed Choice®: Aetna Life Insurance Company Life, Accidental Death & Personal Loss, Disability: Aetna Life Insurance Company HMO, QPOS®: Aetna Health Inc., Aetna Health of California Inc., Aetna Health of the Carolinas Inc., Aetna Health of Illinois Inc., Corporate Health Insurance Company Dental: Aetna Life Insurance Company, Aetna Health Inc., Aetna Dental Inc., Aetna Dental of California Inc.

The plan documents (Schedule of Benefits, Group Agreement, Group Policy, and Certificate of Coverage) will determine my rights and responsibilities and will govern even if they conflict with any benefits comparisons, summary or other description of the plan. I understand and agree that with the exception of Aetna Rx Home Delivery®, all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. The availability of any particular product cannot be guaranteed and provider network composition is subject to change. **NOTICE: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or who 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.**

**Authorization to Deduct Contributions**

I authorize deductions from my earnings of the required contributions, if any, toward the cost of the coverage. This authorization applies only if employee contributions are required.

**Special Provision for Employers with Section 125 Plans**

By allowing an individual to enroll in the Insurance Plan other than open enrollment period, Aetna and Aetna Global Benefits does not waive any terms of its contract. Further, by allowing an individual to enroll in the Insurance Plan other than during an open enrollment period, Aetna and Aetna Global Benefits does not thereby express any opinion regarding the appropriateness of the change under Section 125 of the Internal Revenue Code or the terms of the employer's Section 125 Plan.

**Special State Provisions**

**CA Residents Only:** The Health Plan uses binding arbitration to settle disputes, including claims of medical malpractice and disputes, relating to the delivery of service under the plan. It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. The parties to this contract, by entering into it, are giving up their constitutional right to have any dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. It is understood that this agreement to arbitrate shall apply and extend to any dispute for medical malpractice, relating to the delivery of service under the plan, and to any claims in tort, contract or otherwise, between Group, any individual(s) seeking services under the plan, whether referred to as a Member, Subscriber, Dependant, Enrollee or otherwise (whether a minor or an adult, or the heirs-at-law or personal representatives of any such individuals), as the case may be, and the Health plan (including any of their agents, successor-or predecessors-in-interest, employees, or providers.)

**Kansas Residents Only:** I further agree that in the event I or any of my dependants collect benefits or damages from any other party who has primary responsibility for services provided by the health plan, I will immediately reimburse the health plan to the extent of services provided, to the extent of services provided, to the extent permitted by applicable state law.

**Mid-Atlantic:** A referral from the enrollee's Primary Care Physician is not required for routine gynecological care received from a network gynecologist, out-of-area emergency-urgent care, or out of network care received under the point to service option.

**Georgia:** If you were a former patient of a designated doctor and are now considering selecting that doctor, you are considered a "new patient." I hereby apply for membership in Aetna and Aetna Global and authorize my employer/union/association to deduct any required contribution from earnings. I hereby authorize any physician, hospital, insurer or other organization or person have in any records, data or information concerning health history or medical insurance for me or my family members to furnish such records, data, or information as may be requested by Aetna and Aetna Global, or their duty authorized representative. A photocopy of this authorization shall be considered an effective and valid as the original. Aetna and Aetna Global must be notified of all changes. I authorize that payment be made under Part B of Medicare to Aetna and Aetna Global for medical and other services furnished me for which it pays or had paid.

Employee Signature \_\_\_\_\_

Date \_\_\_\_\_

Print Name \_\_\_\_\_