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Application for Aetna PPO

**ENROLLMENT/CHANGE
FORM**

Aetna PPO
 PPO Plan 500/1000
 PPO Plan 1000/1500
Check one

IMPORTANT PLEASE PRINT ALL SECTIONS IN BLACK INK

SECTION 1 EMPLOYER TO COMPLETE THIS SECTION

| | | | |
|--|--|--|---|
| Company Name | | Phone () | FOR PIBT USE ONLY |
| Address | | GROUP # | |
| New Enrollment <input type="checkbox"/> Change <input type="checkbox"/> <i>Changes (Check appropriate boxes)</i> <input type="checkbox"/> Add dependent - Complete Section 4 <input type="checkbox"/> Name change - Complete Sections 3 and 4 | | Changes of Coverage: Report all additions or changes of group coverage to PIBT no later than the 20th day of the month in which it is effective. | COVERAGE EFFECTIVE DATE PIBT ACCOUNT NO. |

SECTION 2 LIFE INSURANCE BENEFICIARY INFORMATION

| | | | |
|------------------------------|------------------------|--------------|----------------------|
| Life Beneficiary (Full Name) | Address (if different) | Relationship | Must equal 100% % |
| Life Beneficiary (Full Name) | Address (if different) | Relationship | % |

SECTION 3 EMPLOYEE INFORMATION

| | | | | | | |
|---|----------------------------|---|-----------|------------|---|--|
| Last Name | | First Name | | M.I. | <input type="checkbox"/> Single <input type="checkbox"/> Married <i>Date of Marriage</i> _____ <input type="checkbox"/> Domestic Partner <i>Registration Date</i> _____ | |
| Social Security Number | Full Time Hire Date | Employment Status <input type="checkbox"/> Salaried <input type="checkbox"/> Hourly | Job Title | | | |
| Residence Mailing Address (Number, Street, Apartment) | | | City | State | Zip | |
| Home Telephone () | Mobile Phone Number () | Have you or any of your dependents ever been a member of the plan you have selected? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Effective Date Requested (must be 1st of month following employer waiting period) | | | | Occupation | | |

NOTE: An eligible dependent child is an employee's or spouse's child under the age of 26.

SECTION 4 EMPLOYEE/DEPENDENT ENROLLMENT INFORMATION

| Name | Last | First | M.I. | Birthdate MM/DD/YYYY | Sex |
|-------------------|------|-------|------|-------------------------------|--|
| Employee | | | | Birthdate | F <input type="checkbox"/> M <input type="checkbox"/> |
| SS# | — | — | | Relationship Self | |
| Spouse | | | | Birthdate | F <input type="checkbox"/> M <input type="checkbox"/> |
| SS# | — | — | | Relationship Spouse | |
| First dependent* | | | | Birthdate | F <input type="checkbox"/> M <input type="checkbox"/> |
| SS# | — | — | | Relationship | |
| Second dependent* | | | | Birthdate | F <input type="checkbox"/> M <input type="checkbox"/> |
| SS# | — | — | | Relationship | |
| Third dependent* | | | | Birthdate | F <input type="checkbox"/> M <input type="checkbox"/> |
| SS# | — | — | | Relationship | |
| Fourth dependent* | | | | Birthdate | F <input type="checkbox"/> M <input type="checkbox"/> |
| SS# | — | — | | Relationship | |

Please sign and date this application below. Your signature indicates that you have completed all requested information as accurately as possible and that you have read the Plan information including the information listed on pages 2, 3, & 4 of this form and understand all agreements, including your agreement to submit disputes to binding arbitration.

Employee Signature _____ Date _____

SECTION 5 HEALTH CARE COORDINATION

To assist our Medical Management Team in coordinating your care, please answer the following questions:

1. Is anyone listed in Section 4 above currently receiving ongoing medical care for a serious illness or condition? Yes No

If yes, who? _____

2. Does anyone listed in Section 4 above require medical care for a chronic illness or condition? Yes No

If yes, who? _____

SECTION 6 DISABILITY INFORMATION

1. Do you believe that you or any family member for whom you are applying for coverage would be considered totally disabled according to the definitions of disability given on the back of this application?
 Yes No If yes, who?

Disabling Condition(s) _____ Date Disability Commenced _____

SECTION 7 OTHER HEALTH INSURANCE

1. Is anyone listed in Section 4 on previous page eligible for Medicare? Yes No If yes, who? _____

2. Are you or have you and/or any of your eligible family members been covered by other medical coverage within the last six months?
 Yes No If yes, complete the section below. Please list all current or prior medical coverage. **Failure to provide complete information may result in significant delay of claims processing.** (Attach additional sheets if necessary)

| Covered Person's Name | Policy Holder Name(s) | Insurance Company Name(s) | Type of Coverage | Policy No. | Effective Date | Termination Date |
|-----------------------|-----------------------|---------------------------|---|------------|----------------|------------------|
| | | | <input type="checkbox"/> Health <input type="checkbox"/> Other _____ | | | |
| | | | <input type="checkbox"/> Health <input type="checkbox"/> Other _____ | | | |

SECTION 8 ACCEPTANCE OF COVERAGE

Explanation of Authorization to Obtain or Release Medical Information: The authorization below to obtain and release medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act, effective January 1, 1980, Section 56 et seq. of the California Civil Code. Your cooperation is requested. **Authorization to Obtain or Release Medical Information:** I hereby authorize my physician, health care practitioner, hospital, clinic or other medically related facility to furnish an agent, designees or representatives of the plan you selected or Printing Industries Benefit Trust or its agents, designees or representatives, any and all records pertaining to medical history, services rendered or treatment given to anyone enrolled hereunder, or added hereunder for purpose of review, investigation, or evaluation of an application or a claim. I authorize the plan you selected, Printing Industries Benefit Trust or its agents, designees or representatives, to

disclose to a hospital or health care service plan, self-insurer, any such medical information obtained if such disclosure is necessary to allow the processing of any claim. This authorization shall become effective immediately and shall remain in effect as long as is necessary to enable the plan you selected or Printing Industries Benefit Trust or its agents, designees or representatives to process claims and benefits.

Arbitration Agreement: I understand that any dispute or controversy, except medical malpractice, that may arise regarding the performance, interpretation or breach of the agreement between myself (and/or any enrolled family member) and the plan you selected, Printing Industries Benefit Trust or its agents, designees or representatives or any Participating Medical Group/ Independent Physicians Association, whether arising in contract, tort or otherwise, must be submitted to arbitration in lieu of a jury or court trial.

SECTION 9 DISABLING CONDITIONS

If you or a family member were disabled as of the date of termination of coverage with a prior health insurer, you may be entitled to an extension of health benefits according to California Insurance Code § 10128. Under this law, the prior insurer retains responsibility until whichever of the following occurs first: (a) the member is no longer totally disabled; (b) the Maximum benefits of the prior insurer's coverage are paid; or (c) a period of 12 consecutive months has passed since the date coverage ended with the prior insurer.

Total disability, as it relates to the law described above, means: Employee: when, as a result of bodily injury or disease, the employee is unable to engage in any employment or occupation for which he or she is or becomes qualified for by reason of education, training or experience and is not, in fact, engaged in any employment or occupation for wage or profit. Family member: when the family member is prevented from performing all regular and customary activities usual for a person of that age.

Application for enrollment under the plan you selected will not be considered unless the Disability Information section is completed. Please answer the questions as completely as possible to avoid delay in the processing of your application.

SECTION 10 PROVISIONS

I authorize deductions from my earnings of the required contributions, if any, toward the cost of the coverage.

I understand that the Participating Providers, if any, do not necessarily include all types, of doctors or providers.

I authorize payment of benefits to the Participating Provider of the benefits.

I authorize that payment be made under Part B of Medicare to participating provider for medical and other services furnished me for which it pays or has paid, if applicable.

I agree, for myself and my dependents, that in the event any health services provided are the primary responsibility of any other party by way of other group health coverage or by the act or omission of another person to fully inform Printing Industries Benefit Trust and will execute such assignments, liens, or other documents which may be necessary to enable the plan to recover the value of the services provided. I further agree that in the event I or any of my dependents collect benefits or damages from any other party who has primary responsibility for services provided by the plan, I will immediately reimburse the plan to the extent of services provided, to the extent permitted by state law.