# DENISON UNIVERSITY HEALTH ENROLLMENT / CHANGE FORM

**EMPLOYER:** Complete Section A
**EMPLOYEE:** Complete Section B-E

Medical ____________ Dental _________ Vision __________

**A**

| Open Enroll ☐ | Change ☐ | Effective Date | Employer Name | Aetna Acct No. | Div./Class | Medical Option | Dental Option |
|---|---|---|---|---|---|---|---|
| New Enroll ☐ | Reinstate ☐ | | Denison University | 478811 | 001 | | |

**TYPE OF CHANGE:**

| Add Dependent(s) | Cancel Dependent(s) | Trans to Cobra | Cancel Employee | Change in Status |
|---|---|---|---|---|
| Birth ☐ Marriage ☐ | Marriage ☐ Divorce ☐ | 18 mos ☐ | Termination of Employment ☐ | Retirement ☐ |
| Adoption ☐ Other ☐ | Student Status ☐ Other ☐ | 36 mos ☐ | Other Insurance ☐ | Surviving Spouse ☐ |

**B**

| Employee Name (Last) | (First) | (M.I.) | Social Security No. | Home Phone | Work Phone |
|---|---|---|---|---|---|
| | | | | | |

| Address (Street) | (City) | (State) | (ZipCode) |
|---|---|---|---|
| | | | |

**C**

| I WOULD LIKE COVERAGE FOR ME AND MY DEPENDENTS. (Specify last name if different from yours) Last Name / First Name / MI | DATE OF BIRTH MM DD CCYY | GENDER M / F | COVERAGE SELECTION Medical / Dental / Vision | FULL TIME STUDENT? Yes / No | If you choose the Aetna Dental DMO option, enter the dentist's NAME and ID NUMBER below. | EXISTING PATIENT? YES / NO |
|---|---|---|---|---|---|---|
| Employee | | ☐ ☐ | ☐ ☐ ☐ | ☐ ☐ | Name: ID #: | ☐ ☐ |
| Spouse/Domestic Partner (same sex) | | ☐ ☐ | ☐ ☐ ☐ | ☐ ☐ | Name: ID#: | ☐ ☐ |
| Dependent / Relationship | | ☐ ☐ | ☐ ☐ ☐ | ☐ ☐ | Name: ID#: | ☐ ☐ |
| Dependent / Relationship | | ☐ ☐ | ☐ ☐ ☐ | ☐ ☐ | Name: ID#: | ☐ ☐ |
| Dependent / Relationship | | ☐ ☐ | ☐ ☐ ☐ | ☐ ☐ | Name: ID#: | ☐ ☐ |

**D**

**MEDICAL OPTIONS:**

- ☐ Aetna Choice Pos II (PPO)
- ☐ Aetna Health Fund (HRA)
- ☐ Decline Coverage

**DENTAL OPTIONS:**

- ☐ Aetna Dental DMO*
- ☐ Aetna Dental PPO
- ☐ Decline Coverage

**if selecting Aetna DMO, you must select a DMO provider and indicate Provider ID # above in Section C.*

**VOLUNTARY VISION OPTIONS:**

- ☐ VSP Plan B
- ☐ Decline Coverage

**E**

**SIGNATURE** - The information provided above is true and correct to the best of my knowledge.
As required by the Flexible Benefit Plan, I understand that my contributions for medical, dental, and vision insurance will be taken as a pre-tax deduction through payroll.

| EMPLOYEE'S SIGNATURE / DATE | EMPLOYER'S SIGNATURE / DATE |
|---|---|
| | |

Revised: 12/08