aetna™ STAFFING 360 SOLUTIONS

Aetna Enrollment Form

New Enrollment

Date of Hire

_____

Aetna Coverages *(check the coverages you want to enroll in)*

- ☐ Medical ☐ Employee ☐ Spouse ☐ *Child(ren)*
- ☐ Dental ☐ Employee ☐ Spouse ☐ *Child(ren)*
- ☐ Vision ☐ Employee ☐ Spouse ☐ *Child(ren)*

Medical Plan Section (check 1 if enrolling in medical)

- ☐ High Plan *($1,500 /$3,000)*
- ☐ Middle Plan *($3,000/$6,000)*
- ☐ Low Plan *($5,000/$10,000)*

Employee Information

Last Name, First Name, Middle Initial	Birthdate MM/DD/YYYY	Social Security Number	Other Medical/RX Drug Coverage
			☐ Yes ☐ No

Home Address	Apt No	City, State Zip Code

Dependent Information

	Last Name, First Name, Middle Initial	Sex M or F	Birthdate MM/DD/YYYY	Social Security Number	Other Medical/RX Drug Coverage
Spouse		☐ M ☐ F			☐ Yes ☐ No
Child		☐ M ☐ F			☐ Yes ☐ No
Child		☐ M ☐ F			☐ Yes ☐ No
Child		☐ M ☐ F			☐ Yes ☐ No
Child		☐ M ☐ F			☐ Yes ☐ No

If "Yes" to Other Medical and/or RX Drug Coverage above, provide effective dates, name & Policy number of insurance carrier, HMO, or other source and your Member Identification Number	Does any dependent listed above live at a different address than the employee? If yes, please list who and what address.

I certify that all information supplied in this form is true and complete to the best of my knowledge and/or belief. I have read and agree to the Conditions of Enrollment on the reverse side of this Enrollment form.

Employee Signature	Date