AETNA HEALTH ENROLLMENT FORM – CITY OF DALTON

Return Completed for to: Human Resources Office – 2nd Floor City Hall **Email: vbrock@daltonga.gov Fax: 706-281-1264**

- The applicant must sign and date this form.
- This form cannot be considered unless received during open enrollment period or a family status change.

PART A: EMPLOYER SECTION – employer should complete gray shaded area.

EMPLOYER NAME: City of Dalton **EMPLOYER ADDRESS: 300 W. Waugh St. Dalton, GA 30720**

Account Number: _____ **Division//Location/Class:** _____ **Benefit Option:** _____ **Branch Code:** _____

REASON FOR REQUEST: ❑ **Open Enrollment** ❑ **New Enrollment** ❑ **Family Status Change...Date and Reason:** _____

_____

Please print (preferably in black ink).

PART B: EMPLOYEE SECTION – Employee/Retiree should complete information below and sign form

☐ Mr. ☐ Mrs. ☐ Ms. (Check One)

Employee Name _____ Social Security # _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Work Phone Home Phone Employee ID # Sex: ☐ M ☐ F

Home email:		Work email		

Important: You must complete each section below.

Coverage Elections	Single ☐ Employee + 1 ☐ Family ☐ Decline Coverage ☐

DEPENDENT INFORMATION							
I would like coverage for me and my dependents(specify last name if different from yours):	*Name:*	*Employee and Dependent Social Security Number:*	*Date of Birth:*	*Gender: M or F*	*Add*	*Drop*	*Full Time Student: Yes or No*
Spouse:							
Dependent:							
Dependent:							
Dependent:							
Dependent:							
Dependent:							

OTHER HEALTH COVERAGE

Do you or your dependents have other health insurance under a group plan, HMO, or Medicare: ☐ Yes ☐ No If so, please provide the following:

NAME OF PERSON COVERED	SOCIAL SECURITY NO.	EFFECTIVE DATE	MEDICARE Part A	MEDICARE Part B	MEDICARE ID #	MEDICAID	OTHER INS.
			☐	☐		☐	☐
			☐	☐		☐	☐

ACCEPTANCE/DECLINATION

I accept the insurance coverages elected above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my earnings. If I have not elected coverage, I understand that if I wish to participate at a later date, I may be required to furnish evidence of insurability at my own expense and that coverage is subject to the insurance company's approval.

Employee Signature: _____ Date _____

Employer Signature: _____ Date _____