

Cornell Program for Healthy Living An Endowed Program through Aetna Enrollment Form

11/12

| □Decedent spouse/domestic partner | | | | □New enrollment | | | |
|--|--|--|--|--|------------------------------------|--|--|
| Decedent child | | | | □Change | | | |
| Employee Name (last, first, middle initial) | | | | Social Security Number | | | |
| Sex () M () |) M () F Date of Birth / / | | | | | / / | |
| Home Address | | | | | | | |
| City State | | | | Zip | | | |
| Campus Address Telephone | | | ie | Email | | | |
| Primary Care Provider Name (required for Enhanced Wellness Exam | | | | Primary Care Provider Number (required for Enhanced Wellness Exam) | | | |
| Please select the coverage level you would like to enroll in below: | | | | | | | |
| Effective date: / / Coverage: () Individual | | | | () Individual + Spouse/Domestic Partner | | | |
| () Individual + Child(ren) () Individual + Spouse/Domestic Partner + Child(ren) | | | | | | | |
| If you wish to cover yo following: | ur spouse or | domestic partn | er, please ch | eck spo | use 🗆 or do | mestic partner 🗖 and | complete the |
| Name of Spouse or Domestic Partner | | | | Spouse/Domestic Partner Social Security Number | | | |
| Date of Marriage/Partnership Spouse/Domestic Partner | | | | Name of Spouse/Domestic Partner Employer | | | |
| / / Date of Birth / Sex () M () F If employed by Cornell, na | | | | ame of department: | | | |
| Primary Care Provider Name (required for Enhanced Wellness Exam) Primary Care Provider Number Exam) | | | | | | ider Number (required for | r Enhanced Wellness |
| If you wish to cover your eligible dependent child(ren) or your domestic partner's child(ren), complete the following: | | | | | | | |
| Name(s) of child(ren) (last, first, mi) | Date of Birt (mo/day/yr) | ate of Birth Relationship | | le So | cial Security Number: | Primary Care Provider Name (required for Enhanced Wellness Exam) | Primary Care Provider Number (required for Enhanced Wellness Exam) |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| You are eligible for dual elig following requirements: 1. You and your spouse/ 2. You and your spouse/ 3. You have dependent of If you are eligible for dual eligible. | domestic partne domestic partne children covered | r are both endowed e r are both eligible for by the plan. | mployees. participation in | the endow | ed health care p | olan. | |
| Endowed Spouse/Domestic Partner Signature | | | | Date | | | |
| I hereby declare that the information University's health care programuthorize and understand that taken from my paycheck if base the following link: http://hr.co | am for endowed health insurance ck premiums are | employees. I hereby premiums will be re wed. I also agree to | request the insur- troactive to the e | rance there | under to which ate or qualifyin | I am entitled or to which I mag event date. This means that | y become entitled. I double deductions will be |
| Signature | | | | Date | | | |