



Aetna Affordable Health Choices[®]

Tri-Overload Staffing Inc.
800194

Enrollment/Change Request

Insurance plans are underwritten by Aetna Life Insurance Company
and administered by Strategic Resource Company (SRC - An Aetna Company).

TO COMPLY WITH CALIFORNIA LAW, THE TERM "DEPENDENT" SHALL BE CONSTRUED TO INCLUDE A DOMESTIC PARTNER.

Instructions: Read and fill out the Enrollment/Change Request (all pages). Make a copy for yourself. Fax your completed form to 866-313-6570. Mail original form to: Tri-Overload Staffing Inc. Benefits Department, 3130 Wilshire Boulevard, Fourth Floor, Santa Monica, CA 90403

IF YOU ARE NOT CHANGING YOUR EXISTING COVERAGE, YOU DO NOT NEED TO COMPLETE THIS ENROLLMENT/CHANGE REQUEST.

INFORMATION ABOUT YOU

 Complete all information.

Print your name (first, middle initial, last)		Social Security Number	Date of birth (MM/DD/YYYY)	
Home address	Apartment number	City	State	Zip code
Home phone () ()	Work phone () ()	Email address	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Primary language spoken (Idioma principal)

ACTION YOU WANT TO TAKE

 Check the box next to the action you want to take.

I am not currently enrolled and I want to...	<input type="checkbox"/> Enroll in the coverage choices selected below. <input type="checkbox"/> Decline this opportunity to participate.
I am currently enrolled and I want to...	<input type="checkbox"/> Make changes to my current coverage choices (add, increase, drop, decrease) as selected below. All of my other coverage choices will remain the same as previously elected. <i>(If outside of an open enrollment, see "Making Changes Outside of an Open Enrollment.")</i> <input type="checkbox"/> Update my personal and/or my dependent and/or beneficiary information. <input type="checkbox"/> Drop all of my current coverage choices.

Your payroll deductions will be taken after taxes are taken.

YOUR COVERAGE CHOICES

 Check () the box for the level of coverage you want.

Coverage type	Coverage level	Weekly cost
Medical	<input type="checkbox"/> No Medical	
	<input type="checkbox"/> Yourself only	\$ 27.82
	<input type="checkbox"/> Yourself plus one	\$ 70.79
	<input type="checkbox"/> Yourself and family	\$105.14
	Group limited benefit medical coverage is not available if you live and work in New Hampshire.	
Hospital Indemnity	<input type="checkbox"/> No Hospital Indemnity	
	<input type="checkbox"/> Yourself only	\$ 3.45
	<input type="checkbox"/> Yourself plus one	\$ 6.90
	<input type="checkbox"/> Yourself and family	\$ 10.35
	Coverage is not available if you live and work in New Hampshire.	
Vision	<input type="checkbox"/> No Vision	
	<input type="checkbox"/> Yourself only	\$ 1.00
	<input type="checkbox"/> Yourself plus one	\$ 1.70
	<input type="checkbox"/> Yourself and family	\$ 2.40
	Coverage is not available if you live and work in New Hampshire.	
Dental	<input type="checkbox"/> No Dental	
	<input type="checkbox"/> Yourself only	\$ 4.45
	<input type="checkbox"/> Yourself plus one	\$ 8.90
	<input type="checkbox"/> Yourself and family	\$ 14.69
	Short Term Disability (STD)	<input type="checkbox"/> No Short Term Disability
<input type="checkbox"/> Yourself only		\$ 3.50
Coverage is not available if you work in California, Hawaii, New Jersey, New York, Rhode Island, and Puerto Rico.		
Term Life Insurance	<input type="checkbox"/> No Term Life	
	<input type="checkbox"/> Yourself only	\$ 1.54
	<input type="checkbox"/> Yourself and family	\$ 1.88
Please name your beneficiary. _____ Relationship: _____ Social Security Number _____		

YOUR AUTHORIZATION

 You must sign and date this Enrollment/Change Request for all new enrollments or coverage changes.

I represent that all information supplied in this Enrollment/Change Request 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/Change Request.

Your signature _____ Today's date (MM/DD/YYYY)

EMPLOYER GROUP INFORMATION This section is to be completed by your employer.

Employee ID	Hire date (MM/DD/YYYY)	Pay type	Total deduction (\$)	Effective date (MM/DD/YYYY)
Location or site code	Authorized signature		Title	Today's date (MM/DD/YYYY)

INFORMATION ABOUT YOU Repeat your name and Social Security number here.

Print your name (first, middle initial, last) Social Security Number

INFORMATION ABOUT YOUR DEPENDENTS List the dependents for whom you are adding/changing/removing coverage.

If you have more dependents, write down their information on a separate sheet and attach it to this Enrollment/Change Request.

<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Print dependent's name (first, middle initial, last)		Social Security Number	
	Sex <input type="checkbox"/> Male / <input type="checkbox"/> Female	Date of birth	Enrolled in: <input type="checkbox"/> Medical / <input type="checkbox"/> Hospital Indemnity / <input type="checkbox"/> Vision / <input type="checkbox"/> Dental / <input type="checkbox"/> Term Life	
	Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Registered domestic partner <input type="checkbox"/> Child <input type="checkbox"/> Other (Specify): _____			
	Address (if different than yours)		City	State

<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Print dependent's name (first, middle initial, last)		Social Security Number	
	Sex <input type="checkbox"/> Male / <input type="checkbox"/> Female	Date of birth	Enrolled in: <input type="checkbox"/> Medical / <input type="checkbox"/> Hospital Indemnity / <input type="checkbox"/> Vision / <input type="checkbox"/> Dental / <input type="checkbox"/> Term Life	
	Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Registered domestic partner <input type="checkbox"/> Child <input type="checkbox"/> Other (Specify): _____			
	Address (if different than yours)		City	State

<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Print dependent's name (first, middle initial, last)		Social Security Number	
	Sex <input type="checkbox"/> Male / <input type="checkbox"/> Female	Date of birth	Enrolled in: <input type="checkbox"/> Medical / <input type="checkbox"/> Hospital Indemnity / <input type="checkbox"/> Vision / <input type="checkbox"/> Dental / <input type="checkbox"/> Term Life	
	Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Registered domestic partner <input type="checkbox"/> Child <input type="checkbox"/> Other (Specify): _____			
	Address (if different than yours)		City	State

MAKING CHANGES OUTSIDE OF AN OPEN ENROLLMENT Please read below to see if you are able to make changes to your coverage.

You can add to or increase your coverage during the plan year only if you have a **Qualifying Life Event (QLE)**. If your deductions are taken after taxes, you may drop or decrease coverage at any time. QLEs fall under one of these two categories:

Loss of Other Coverage (LOC): If you previously declined health coverage because you or your dependents were already covered under another health plan and you or your dependents have lost that other coverage, you may be able to enroll yourself and your dependents. If you had a recent LOC, go to the list on the right and check the box next to your LOC and supply the date of the LOC.

Family Status Change (FSC): Whether you are currently enrolled or previously declined coverage, you may be able to add or increase coverage when you experience certain FSC events. If you had a recent FSC, go to the list on the right and check the box next to your FSC and supply the date of the FSC.

Next, complete the rest of this Enrollment/Change Request. When finished, make a copy and submit it to your employer with your documentation attached. You must submit this Enrollment/Change Request, together with documentation, to your employer within 31 days of the LOC/FSC.

Loss of Other Coverage (LOC):

- Divorce, legal separation or death
- Termination of employment of a dependent
- Reduction of a dependent's hours
- Termination of your or your dependents' COBRA rights
- Loss of employer's contribution to spouse's or registered domestic partner's coverage
- Dependent child losing eligibility as a dependent
- Other loss of coverage

Family Status Change (FSC):

- Divorce, legal separation or death
- Marriage
- Birth or adoption of a dependent
- Other

Date of LOC or FSC (mm/dd/yyyy)

NOTICE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

On behalf of myself and the dependents listed on this Enrollment/Change Request, I agree to or with the following:

1. I acknowledge that by enrolling in an Aetna plan coverage is underwritten by Aetna Life Insurance Company (referred to as "Aetna") 151 Farmington Avenue, Hartford, CT 06156 and administered by Strategic Resource Company (SRC, an Aetna company), 221 Dawson Road, Columbia, SC 29223.
2. I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments as required for coverage.
3. **For life and disability coverages:** I understand that the effective date of insurance for myself or for any of my dependents, if applicable, is subject to my being actively at work on that date and that the effective date of insurance for any of my dependents is also subject to the dependent health condition requirements of the benefit plan. I understand that, in the event I fail to sign this form within 31 days of the effective date of eligibility or that for any reason Aetna does not receive notice of the Enrollment/Change Request within a reasonable time following the date I was eligible to enroll or change my coverage, my and my dependents' eligibility, if applicable, may be affected. Further, I understand that any insurance subject to evidence of good health or medical information will not become effective until Aetna gives its written consent.
4. I understand and agree that this Enrollment/Change Request may be transmitted to Aetna or its agent by my employer or its agent. I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("Providers") to give Aetna or its agent information concerning the medical history, services or treatment provided to anyone listed on this Enrollment/Change Request, including those involving mental health, substance abuse and AIDS. I further authorize Aetna to use such information and to disclose such information to affiliates, providers, payors, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. I have discussed the terms of this authorization with my spouse and competent adult dependents and I have obtained their consent to those terms. I understand that this authorization is provided under state law and that it is not an "authorization" within the meaning of the federal Health Insurance Portability and Accountability Act. This authorization will remain valid for the term of the coverage and so long thereafter as allowed by law. I understand that I am entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original.
5. The plan documents will determine the rights and responsibilities of member(s) and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
6. I understand and agree that with the exception of Aetna Rx Home Delivery®, all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.
7. **Misrepresentation:** Any person who knowingly and with intent to defraud or deceive any insurance company files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.