Human Resources
Enrollment/Coverage Change Form

Instructions: To enroll in a plan please complete all information for yourself and covered dependents. To add or delete a dependent to a plan please complete the below information for each dependent you are adding or deleting and indicate what plan you are adding or deleting them from. If you have more than four dependents use a 2nd form.

Name of Bates Employee:					Bates ID Number:
1	**Add**	**Delete**	First:	Middle:	Last:
	○ ACO ○ PPO ○ HSA ○ Dental ○ Vision	○ ACO ○ PPO ○ HSA ○ Dental ○ Vision	○ Male ○ Female DOB: SSN:	○ Self ○ Spouse ○ Partner ○ Child	**For ACO Only:** **Doctor's name:** **Provider ID:** __ __ __ __ __ __
2	**Add**	**Delete**	First:	Middle:	Last:
	○ ACO ○ PPO ○ HSA ○ Dental ○ Vision	○ ACO ○ PPO ○ HSA ○ Dental ○ Vision	○ Male ○ Female DOB: SSN:	○ Self ○ Spouse ○ Partner ○ Child	**For ACO Only:** **Doctor's name:** **Provider ID:** __ __ __ __ __ __
3	**Add**	**Delete**	First:	Middle:	Last:
	○ ACO ○ PPO ○ HSA ○ Dental ○ Vision	○ ACO ○ PPO ○ HSA ○ Dental ○ Vision	○ Male ○ Female DOB: SSN:	○ Self ○ Spouse ○ Partner ○ Child	**For ACO Only:** **Doctor's name:** **Provider ID:** __ __ __ __ __ __
4	**Add**	**Delete**	First:	Middle:	Last:
	○ ACO ○ PPO ○ HSA ○ Dental ○ Vision	○ ACO ○ PPO ○ HSA ○ Dental ○ Vision	○ Male ○ Female DOB: SSN:	○ Self ○ Spouse ○ Partner ○ Child	**For ACO Only:** **Doctor's name:** **Provider ID:** __ __ __ __ __ __

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Print Your Name Signature Date

DOB: Date of Birth, **SSN:** Social Security Number, **HSA:** Aetna Consumer Choice (HSA) Plan, **ACO:** Aetna Whole Health Plan, **PPO:** Aetna PPO Plan