Aetna US Healthcare

Life and Disability Enrollment/Change Request

Aetna Life Insurance Company

Effective Date	Employee Hire Date

Employee Social Security Number: - -

A. Transaction Information

1. Enrollment
- ☐ New Employee
- ☐ Retiree
- ☐ Rehire/Reinstatement

/ /

Requested Employee Coverage
- ☐ Basic Life
- ☐ AD&PL/AD&D
- ☐ Supplemental Life
- ☐ Supplemental AD&PL/AD&D
- ☐ Short Term Disability
- ☐ Long Term Disability

Requested Dependent Coverage
- ☐ Basic Dependent Life
- ☐ Basic Dependent AD&PL/AD&D
- ☐ Supplemental Dependent Life
- ☐ Supplemental Dependent AD&PL/AD&D

2. Termination (Cancel)
- ☐ Employee *

* Employee must be enrolled for dependent(s) to have coverage.

3. Change (*Provide explanation in Section D, Special Remarks.)
- ☐ Add Dependent(s) (Life ONLY)
- ☐ Remove Dependent(s) (Life ONLY)
- ☐ Plan Change
- ☐ Increase/Decrease Benefit Amount*
- ☐ Other*

B. Employer Information - Please Print all Information

1. Employer Name - Full Name of Business or Organization	2. Control No.	Suffix	Account	3. Plan Number	4. SFO
Tulsa Firefighter's Health and Welfare Trust	100527				158

5. Employer Address (Street, City, State, ZIP Code) - Primary Location of Business or Organization	6. Claim Office Code	7. Customer Code (Optional)
6100 S. Yale Ave. Ste. 1900 Tulsa, OK 74136		

C. Employee Information - Please Print all Information

1. Employee Name (Last, First, Middle Initial)	2. Birthdate (MM/DD/YYYY)	3. Sex	4. Telephone Numbers
	/ /		Home ( ) - Work ( ) -

5. Employee Home Address (Number, Street, City, State, ZIP Code)	6. Employee Annual Earnings	7. Occupation/Title	8. Work State
	$		

6. Employee Coverage Amounts - Based on the requirements of your Plan, you may have to submit evidence of good health. (Life Insurance ONLY)

Basic Life Amount	Supplemental Life Amount	Basic AD&PL/AD&D Amount	Supplemental AD&PL/AD&D Amount
$	$	$	$

7. Beneficiary Designation - If more than one beneficiary, use Special Remarks. Dependent coverage Beneficiary is always the Employee. (Life Insurance ONLY)

Full Beneficiary Name (First, Middle, Last)	Social Security Number of Beneficiary	Relationship to Employee
	- -	

D. Covered Dependents - Complete only if Dependent Coverage is offered under your Plan.

☐ **Check this box if you are refusing coverage for your dependents. (Life Insurance ONLY)**

(A)dd/New (C)hange (R)emove	Dependent Name (First, Middle Initial, Last)	Social Security Number (If dependent has no SSN, write "None")	Relation. Code	Birthdate MM / DD / YYYY	Student Age 19 or Older Yes No	Basic Dependent Amount	Supplemental Dependent Amount	Basic Dependent AD&PL/AD&D Amount	Supplemental Dependent AD&PL/AD&D Amount
		- -		/ /	☐ ☐	$	$	$	$
		- -		/ /	☐ ☐	$	$	$	$
		- -		/ /	☐ ☐	$	$	$	$
		- -		/ /	☐ ☐	$	$	$	$

Special Remarks

E. Certification - Signatures Required

Employee's E-mail Address:

My signature below signifies my agreement with the statements and authorization under **Certification and Authorization** on the back of this form.

1. Employee Signature	Date	2. Employer Signature	Date
X		X	