

AETNA Benefit Enrollment / Change Form

ELIGIBLE JOCKEY		DEPENDENTS			
First Name	Cricle Appropriate Single Married Male Female Active Retired	Spouse (First - MI - Last)	Date of Birth	SSN	Gender M F
Middle Name		Child (First - MI - Last)	Date of Birth	SSN	Gender M F
Last Name	Date of Birth	Child (First - MI - Last)	Date of Birth	SSN	Gender M F
Street Address	SSN	Child (First - MI - Last)	Date of Birth	SSN	Gender M F
City	Cell Phone	Child (First - MI - Last)	Date of Birth	SSN	Gender M F
State	Zip Code	Home Phone	Child (First - MI - Last)	Date of Birth	SSN Gender M F
Email	Date Eligible	Child (First - MI - Last)	Date of Birth	SSN	Gender M F
PLAN SELECTION		SIGNATURE			
Plan 1 <input type="checkbox"/> Zero Deduct Plan 3 <input type="checkbox"/> HSA	Plan 2 <input type="checkbox"/> \$2000 Deduct Plan 4 <input type="checkbox"/> HMO (CA only)	By signing below I declare that all the information given in this enrollment form is true and complete to the best of my knowledge and belief. This authorization applies to such coverages until it is rescinded in writing.		By signing below I acknowledge that I have read and understand the statements and declarations made in this enrollment form.	

Print Name: _____

Signature: _____

Date: _____

