



**Florida Supplemental Enrollment Information Form**  
**Implementing 2008 SB 2534, FL Stat. Ann, § 627.656**  
 Aetna Health Inc./Aetna Life Insurance Company

**A. Group & Employee Information**

Group Name	Group Number/Control Number
Employee Name	Employee's Aetna ID Number

**B. Type of Activity (see Important Explanatory Information below)**

**Change** - Check all that apply.  
 Date of Event  
 \_\_\_\_/\_\_\_\_/\_\_\_\_

Add dependent over the limiting age, but less than 30  
 Remove dependent over the limiting age, but less than 30  
 Reason(s): \_\_\_\_\_

**Continuation of Coverage pursuant to 2008 SB 2534, FL Stat. Ann, § 627.656**

Date of Event  
 \_\_\_\_/\_\_\_\_/\_\_\_\_

**Coverage is being effected:**  
 During an Open Enrollment  
 Within 30 days prior to attainment of limiting age  
 Within 30 days after eligibility for other reasons

**C. Over-age Dependent Information**

Name (Last, First, MI)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate (MM/DD/YYYY) ____/____/____	Dependent's Aetna ID Number
Other Health Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No	Other RX Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Primary Physician Office ID Number: _____	Ob/Gyn Physician Office ID Number: _____		
Current Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
Previous Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, provide the following information AND submit a copy of the certificate of Creditable Coverage that was issued by the previous carrier, if available:		
Effective date of prior coverage: ____/____/____	Termination date of prior coverage: ____/____/____		
Name of prior carrier: _____	Prior plan number: _____		

**D. Signatures**

Employee	Date
Dependent	Date

**IMPORTANT EXPLANATORY INFORMATION**

A dependent child may request to continue as a dependent on his or her parent's coverage after the child reaches the limiting age under the terms of the policy if he or she:

- Is not yet 30 years old;
- Is unmarried;
- Has no children;
- Is a resident of Florida or, if not a Florida resident is a full or part-time student at an accredited institution of higher education; and
- Is not eligible for Medicare and is not actually covered under another group or individual health plan.

The employee may make the request to continue the dependent's child coverage:

- When he or she has reaches the limiting age, or
- During the open enrollment period for the group of which the parent is a member on or after October 1, 2008.

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability. Aetna provides free aids/services to people with disabilities and to people who need language assistance. If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card. If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,  
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),  
**1-800-648-7817**, TTY: **711**,  
Fax: **859-425-3379** (CA HMO customers: **860-262-7705**)  
Email: **CRCoordinator@aetna.com**.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at **1-800-368-1019**, **800-537-7697** (TDD).

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