

Instructions for Employees completing this form:

Section A **Item 1 or Item 3** Indicate the type of transaction as appropriate.

- Section B **Item 4** Employee name must always be completed. If changing, enter former name, draw a line through it and enter new name directly above.  
**Item 5** Must be complete beginning with the month, date and year.  
**Item 6** Must be completed by circling M or F.  
**Item 7** Enter your 9-digit social security number here.  
**Item 8** Enter your 5-digit employee identification number here  
**Item 9** Show full name of person to whom benefits will be paid in the event of your death. Always show given name; do not show as Mrs John J Smith or MJ Smith. If more than one beneficiary omit item 9 and show full details in special remarks section (item #11). Please see item 12.  
**Item 10** Indicate relationship of beneficiary e.g.; friend, wife, daughter. If more than one beneficiary is indicated in item 9, omit item 9 & 10 and show full details in special remarks section (item #11).  
**Item 11** Use for further explanation concerning any item. For separations this section will be used by the Employer only.  
**Item 12** Please indicate each beneficiary's address if different from yours.

**Section C and D to be completed by Employer**

You must sign and date this form after completing and return it to your Benefits Representative in the Personnel Department for processing. You may contact your Benefits Representative for any questions or further instructions. Do not contact Aetna Life Insurance Company directly, unless otherwise instructed.

Certification and Authorization

I certify that all information on this form is true and complete to the best of my knowledge and belief. I understand that this insurance is subject to all of the terms of the Plan of Insurance contained in the group policy and summarized in the announcement material provided me and the certificate issued to me. I understand that the effective date of insurance for myself or for any of my dependents is subject to my being actively at work on that date. Further, I understand that any insurance subject to evidence of good health or medical information will not become effective until Aetna gives it written consent. 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 event, my and my dependents eligibility may be affected. I request my employer to arrange for the issuance of Group Life Coverage for which I am or may become eligible and authorize deductions of the required contributions from my earnings.

Misrepresentations

Any person who knowingly and with intent to defraud any insurance company or other person 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.

PLEASE TYPE OR PRINT WITH BALL POINT PEN

<b>AETNA</b> <b>US HEALTHCARE</b>		Section A: Transaction Information				
1. Enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> Rehire or Reinstatement		2. Termination <input type="checkbox"/> Cancel Coverage		3. Change <input type="checkbox"/> Change Beneficiary <input type="checkbox"/> Other (see #11)		
Section B: Employee Information						
4. Employee Name (Last, First, Middle Int.)			5. Birthdate (mm/dd/yy)	6. Sex M / F	7. Social Security No / /	
8. Employee ID #	9. *Beneficiary Designation-If more than one beneficiary, use <i>Special Remarks #11</i>			Beneficiary SS # / /		10. Relationship
11. Special Remarks: _____ _____						
*12. Beneficiary address if different from yours _____						
My signature below signifies my agreement with the statements and authorization on <i>Certification and Authorization</i> contained in this form. Employee _____ Date _____ Signature X _____ Signed _____						
Section C: Employer Information						
Employers Name <b>Oakland County</b>	Employers Address (street, city, state, zip code) <b>1200 N Telegraph Rd Pontiac, MI 48341</b>			CONTROL <b>46400</b>	SUFFIX	ACCT
				SFO <b>203</b>	C. O. <b>174</b>	
Section D: OFFICE USE ONLY						
Employer Signature: X _____		Date Signed _____	Effective Date:	Employment/Return to Work Date:	Bi-weekly Salary:	