



# Primary Care Selection Form

## Aetna EPO (Open Access Aetna Select<sup>SM</sup>)

- **Open Enrollment:**  
Please return this form by **May 15<sup>th</sup>**.
- **New Enrollees:**  
Please return this form within **two weeks** of plan selection.

**Dear State of Maryland Employee:**

Thank you for choosing Aetna EPO for your medical coverage for the coming year.

Once you have completed your State Enrollment Form, you will need to select a Primary Care Physician using this form. Please complete and fax to **215-775-6539** (confidential number). We look forward to providing you and your family with quality health coverage for the coming year.

If you have any questions about completing this form, or about your coverage, please call our Maryland Member Services number (1-800-501-9837).

Type of Enrollment			
<input type="checkbox"/> Self only	<input type="checkbox"/> Self and spouse	<input type="checkbox"/> Self and Child	<input type="checkbox"/> Self and two or more dependents
State Agency Name		Payroll Office Number (If known)	
Home Address		City	State      Zip Code
Work Telephone Number		Home Telephone Number	

**Complete the following information for each person to be covered by Aetna.**

Employee	Last Name	First Name	MI	M/F	Date of Birth (MM/DD/YYYY)	Social Security Number	Provider ID Number*	Current Patient <input type="checkbox"/> Yes
Spouse	Last Name	First Name	MI	M/F	Date of Birth (MM/DD/YYYY)	Social Security Number	Provider ID Number*	Current Patient <input type="checkbox"/> Yes
Dependent Child	Last Name	First Name	MI	M/F	Date of Birth (MM/DD/YYYY)	Social Security Number	Provider ID Number*	Current Patient <input type="checkbox"/> Yes
Dependent Child	Last Name	First Name	MI	M/F	Date of Birth (MM/DD/YYYY)	Social Security Number	Provider ID Number*	Current Patient <input type="checkbox"/> Yes
Dependent Child	Last Name	First Name	MI	M/F	Date of Birth (MM/DD/YYYY)	Social Security Number	Provider ID Number*	Current Patient <input type="checkbox"/> Yes
Dependent Child	Last Name	First Name	MI	M/F	Date of Birth (MM/DD/YYYY)	Social Security Number	Provider ID Number*	Current Patient <input type="checkbox"/> Yes

**\*Please refer to [www.aetnamd.com](http://www.aetnamd.com) for provider ID number.**

Employee's Signature	Date
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Please fax to 215-775-6539 (confidential number). Please **DO NOT** give this form to your benefits department.

**Make a copy of the completed form for your records.**