New Jersey Enrollment/Change Request
Aetna Health Inc.

Employer Group Information - To Be Completed by Employer

Group Name	Group Number	Class Code

A. Type of Activity - To Be Completed by Employer To Add, Change or Remove coverage for dependents over the limiting age, but less than 30, Aetna form HINT Supplemental Enrollment Information Form, Implementing P.L. 2005, c. 375, must be completed. *Refer to instructions on back before completing this form. Print clearly.*

1. Enrollment

☐ New Enrollee/Subscriber

Effective Date ___/___/___

Date of Hire ___/___/___

2. Change - *Check all that apply.*

	Date of Event	Reason
☐ Add Spouse/Civil Union Partner	___/___/___	
☐ Add Domestic Partner	___/___/___	
☐ Add Dependent Child	___/___/___	
☐ Name Change	___/___/___	
☐ Change Plan	___/___/___	
☐ Other	___/___/___	

☐ Add/Change **Primary** Office ID Number and/or NPI Number

3. Remove or Terminate - *Check all that apply.*

	Effective Date	Reason
☐ Remove Spouse/Civil Union Partner*	___/___/___	
☐ Remove Domestic Partner*	___/___/___	
☐ Remove Dependent Child*	___/___/___	
☐ Employee Withdrawal/Termination	___/___/___	

NOTE: Employee must be enrolled for spouse/civil union partner/dependent(s) to have coverage.

* Please complete *Add/Change/Remove* and *Name* columns in Section D.

4. Continuation of Coverage, i.e., COBRA, State, Total Disability - *Not all options are available or applicable. Contact Employer for available options.*

Coverage For: ☐ Employee ☐ Spouse/Civil Union Partner* ☐ Dependents

Length of Continuation: ☐ 12 mos ☐ 18 mos ☐ 29 mos ☐ 36 mos ☐ Total Disability - Attach proof of total disability

Date of Loss of Coverage: ___/___/___

Date of Qualifying Event: ___/___/___

* Civil Union Partners are ineligible to make an election for COBRA continuation.

B. Employee Information - Complete Sections B - G.

Last Name, First Name, M.I.	Social Security Number	Home Telephone ( )

Home Address	Apt. No.	City, State	ZIP Code

Employer Name	Email Address	Work Telephone ( )	Date of Employment:	Hours Worked Per Week:

Work Address	City, State	ZIP Code

C. Plan Options - Your selection(s) must be offered by your employer.

☐ HMO ☐ QPOS®
☐ Aetna Open Access™ HMO
☐ Aetna Choice™ POS
☐ Aetna Health Network Option℠
☐ Aetna Health Network Only℠

Available options with Aetna Health Network Option and Aetna Health Network Only.
Check all that apply.

☐ Aetna HealthFund™
☐ Aexcel®
☐ Aexcel® Plus

Indicate Plan Name

Primary Copay:
☐ $5 ☐ $10
☐ $15 ☐ Other $ ____

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. **Attach sheet to list additional children. Attach proof if full-time post secondary student.**

	(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex M F	Birthdate MM DD YYYY	Social Security Number	Other Health Coverage Yes	Other Rx Drug Coverage Yes	Primary Office ID Number	NPI Number	Current Patient Yes	Previous Coverage Check if yes
Employee			☐ ☐	/ /		☐	☐			☐	☐
Spouse/Civil Union Partner			☐ ☐	/ /		☐	☐			☐	☐
Domestic Partner			☐ ☐	/ /		☐	☐			☐	☐
Child			☐ ☐	/ /		☐	☐			☐	☐
Child			☐ ☐	/ /		☐	☐			☐	☐
Child			☐ ☐	/ /		☐	☐			☐	☐

E. Other/Previous Insurance

Is your Spouse/Civil Union Partner employed? ☐ Yes ☐ No If "Yes," give name & address of your spouse/civil union partner's employer.	If "Yes" to Other Rx Drug Coverage (Section D), give name & policy number of insurance carrier, HMO, or other source.
If "Yes" to Other Health Coverage (Section D), give names & policy numbers of insurance carrier, HMO, or other source. If enrolled in Medicare Parts A and/or B identify the coverage and provide the Medicare ID number.	If "Yes" to Previous Coverage, identify name(s) of persons, give effective date and date coverage terminated, name of previous carrier and plan number and submit a copy of the Certificate of Creditable Coverage that was issued by the previous carrier, if available.

F. Dependent Information

Does any dependent listed in Section D live at a different address than the Employee?
☐ Yes ☐ No If "Yes," who and what address?

Explain the circumstances.

If any dependent's last name differs from yours, explain the circumstances.

*If you have questions concerning the benefits and services provided by or excluded under this Agreement, contact a Member Services representative at **1-800-323-9930** before or after signing this form.*

G. Employee Signature

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the reverse side of this Enrollment/Change Request. I authorize deductions from my earnings for any required contributions.

Employee Signature - *Required*
X

Date ___/___/___ E-Mail Address

H. Employer Verification - To Be Completed by Employer

Employer Signature - *Required*
X

Title Date ___/___/___

Employee copy may be used as a temporary ID card for 30 days from the effective date if authorized by employer. Coverage must be verified with Aetna Health Inc. prior to visiting a specialist or admission to a hospital.

Instructions

Employer

- Complete the **Employer Group Information** in the upper right corner of the form.
- **Section A - Type of Activity:**
  - Check boxes indicating reason(s) for submitting Enrollment/Change Request.
- Complete **Section H - Employer Verification** in the lower right corner of the form.
  - Employer must complete this section for all new enrollments, coverage changes and terminations.
  - Employer must sign and date the Enrollment/Change Request in order for it to be processed.

Employee - Complete Sections B - G.

Section B - Employee Information:

- Do not complete this form for dependents over the limiting age, but less than 30; Aetna form HINT Supplemental Enrollment Information Form Implementing P.L. 2005, c.375 must be completed.
- Complete **all** information in order for your Enrollment/Change Request to be processed.

Section C - Plan Option:

- Check *one* Plan Option box in the left column. If you have selected the Aetna Health Network Option or Aetna Health Network Only, check *all that apply* in the right column.
- Where applicable, indicate Plan Option Name and check *one* Primary Copay.
- Select only an option offered by your employer.

Section D - Individuals Covered:

- Add/Change/Remove - Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependents, if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
- If a dependent is a full-time post secondary student, you **must** attach a current course schedule or a letter from the school or its authorized representative confirming full-time student status if dependent is disabled and being continued beyond the limiting age, attach proof of disability.
- If you or your dependent(s) have other Health or Rx drug coverage, check off the "Yes" box(es) and complete Section E - Other/ Previous Insurance.
- From the appropriate provider directory, locate the office 6 digit ID number for the primary care physician. Indicate office ID number selection on the form.
- You can obtain the providers' correct names and addresses from the appropriate provider directory. You may also obtain each provider's NPI number by contacting the provider directly. Providers with multiple office locations and individual providers who belong to more than one practice or provider entity may have more than one NPI number. You should confirm the correct NPI number for the specific provider and office location where you will be seen by contacting that office directly.
- If you are a current patient, please check the "Current Patient" box.

Section E - Other/Previous Insurance:

Complete this section for all new enrollments or coverage changes. Coverage includes group coverage, governmental coverage, a church plan or Medicare.

Section F - Dependent Information:

Complete this section for all new enrollments or coverage changes.

Section G - Employee Signature:

- Complete this section for all new enrollments, coverage changes and terminations.
- Employee must sign and date the Enrollment/Change Request in order for it to be processed.

Section H - Employer Verification:

- Employer must complete this section for all new enrollments, coverage changes and terminations.
- Employer must sign and date the Enrollment/Change Request in order for it to be processed.

Conditions of Enrollment

Applicant Acknowledgments and Agreements

On behalf of myself and the dependents listed on the reverse side, I agree to or with the following:

1. a) I authorize the sources stated below to give to Aetna Health Inc. information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition. Authorized sources are any physician or medical professional; any hospital, clinic or other medical care institution; any carrier; any employer.
   b) I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which Aetna Health Inc. has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
   c) I know that I have a right to receive a copy of the authorization if I request one.
   d) I agree that a photocopy of the authorization is as valid as the original.
2. I acknowledge by enrolling in an Aetna Health Inc. plan, coverage is provided by Aetna Health Inc. in accordance with the contract.
3. Enrollment of myself and of the listed dependents into the plan is effective on acceptance by Aetna Health Inc.
4. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. My employer is hereby authorized to withhold payments from my wages, as appropriate.

Misrepresentation

5. Any person who includes any false or misleading information on an Enrollment/Change Request form for a health benefits plan is subject to criminal and civil penalties.