New Jersey Small Group Enrollment/Change Request
Aetna Health Inc. / Aetna Life Insurance Company

Aetna HMO, HNOnly, HNOption and POS plans are underwritten by Aetna Health Inc. Aetna Indemnity, EPO, and MC plans are underwritten by Aetna Life Insurance Company.

Employer Group Information – To Be Completed by Employer

Group Name			
HMO Only – Group No.	Class Code		
PPO Only – Control No.	Suffix	Account No.	Plan No.

A. Type of Activity – To Be Completed by Employer. To Add, Change, or Remove coverage for dependents over the limiting age, but less than 31, Aetna Form HINT Supplemental Enrollment Information Form Implementing P.L. 2005, c. 375, must be completed. *Refer to instructions on Page 3 before completing this form. Please 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	___/___/___	

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* ☐ Dependent(s)

Length of Continuation: ☐ 18 mos. ☐ 29 mos. ☐ 36 mos. ☐ Total Disability**

Date of Loss of Coverage: ___/___/___

Date of Qualifying Event: ___/___/___

*Civil union partners are eligible to make an election pursuant to NJSGC, if applicable.

**Attach proof of total disability.

B. Employee Information – Complete Sections B - I.

Social Security Number	Last Name, First Name, M.I.			Home Telephone ( )
Home Address	Apt. No.	City, State		ZIP Code
Employer Name		E-Mail Address		Work Telephone ( )
Work Address		City, State		ZIP Code
Date of Employment		Hours Worked Per Week		

C. Medical Plan Options – Your selection must be offered by your employer.

Check One.

☐ NJ HMO: Plan Option: ________ Rx Option: ________

☐ NJ HMO HSA Compatible: Plan Option: ________
Plan Administration: ☐ Cal Yr ☐ Plan Yr

☐ NJ Savings Plus HMO: Plan Option: ________

☐ NJ Savings Plus HMO HSA Compatible: Plan Option: ________
Plan Administration: ☐ Cal Yr ☐ Plan Yr

☐ NJ HNOnly: Plan Option: ________ Rx Option: ________

☐ NJ HNOnly HSA Compatible: Plan Option: ________ Rx Option: ________
Plan Administration: ☐ Cal Yr ☐ Plan Yr

☐ NJ Savings Plus HNOnly: Plan Option: ________

☐ NJ Savings Plus HNOnly HSA Compatible: Plan Option: ________
Plan Administration: ☐ Cal Yr ☐ Plan Yr

☐ NJ QPOS: Plan Option: ________

☐ NJ HNOption: Plan Option: ________

☐ NJ HNOption HSA Compatible: Plan Option: ________ Rx Option: ________
Plan Administration: ☐ Cal Yr ☐ Plan Yr

☐ NJ OA EPO: Plan Option: ________

☐ NJ OA EPO HSA Compatible: Plan Option: ________
Plan Administration: ☐ Cal Yr ☐ Plan Yr

☐ NJ MC: Plan Option: ________

☐ NJ OA MC: Plan Option: ________

☐ NJ OA MC HSA Compatible: Plan Option: ________
Plan Administration: ☐ Cal Yr ☐ Plan Yr

☐ NJ Indemnity: Plan Option: ________

☐ Other Plan: ________

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. Attach proof of disability.

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

E. Other/Previous Coverage

Is your Spouse/Civil Union Partner/Domestic Partner Employed? ☐ Yes ☐ No If "Yes," give name & address of spouse/civil union partner's/domestic partner's employer.

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 **Other Rx Drug Coverage** (Section D), give name & policy number of insurance carrier, HMO, or other source.

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 at what address?

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

G. Race/Ethnicity – To be completed by the Employee, at his/her option. *NOTE: your response is appreciated but NOT required!*

Choose a category that most closely describes you:

☐ American Indian or Alaskan Native ☐ Black, not of Hispanic origin ☐ Hispanic
☐ Asian or Pacific Islander ☐ White, not of Hispanic origin

Employee Signature

If you have questions concerning the benefits and services provided by or excluded under this Agreement, contact a Member Services representative at 1-866-529-2517 (for HMO, HNOnly and HNOption products) or 1-888-802-3862 (for Traditional or PPO Products) before or after signing this form.

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

Employee Signature - *Required* X	Employee E-mail Address	Date

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. and/or Aetna Life Insurance Company 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 application.
  - Complete **Section J – Employer Verification** on Page 3 of this form.
  - Employer must complete this section for all new enrollments, coverage changes and terminations.
  - Employer must sign and date the Enrollment/Change Request form in order for it to be processed.

Employee – Complete Sections B – I.

Section B – Employee Information:

- Complete all information in order for your application to be processed.

Section C – Medical Plan Options:

- Check one Plan Option box and indicate Plan Option name (where applicable) and check one copay.
- Select only an option offered by your employer.

Section D – Individuals Covered:

- Do not complete this form for dependents over age 26, but less than 31; Aetna Form, HINT Supplemental Enrollment Information Form Implementing P.L. 2005, c. 375, must be completed.
- 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 names(s) of your dependents, if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
- If dependent is disabled and being continued beyond age 26, attach proof of disability.
- If you or your dependent(s) have other Health or Rx drug coverage, check the "Yes" box(es) and complete Section F – Other/Previous Coverage.
- If a dependent is Handicapped & financially dependent, check "Yes" & provide proof of handicapped status from the attending physician.
- From the appropriate directory, locate the **6-digit** office ID number for the primary care physician and/or dentist (if applicable). Indicate office ID number selection(s) on the form.
- You may 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 the office directly.
- If you are a current patient, please check the ""Current Patient" box.

Section E – Other/Previous Coverage:

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

Section F – Dependent Information:

Complete this section for all new enrollments or coverage changes.

Employee Signature:

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

Employer Verification:

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

Conditions of Enrollment – Applicant Acknowledgements and Agreements

On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer reporting agency, and any employer to give Aetna Health Inc. and/or Aetna Life Insurance Company, or any consumer reporting agency acting on behalf of Aetna Health Inc. and/or Aetna Life Insurance Company, information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that Aetna Health Inc. and/or Aetna Life Insurance Company has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one.
4. I agree Aetna Health Inc. and/or Aetna Life Insurance Company will provide coverage in accordance with the terms of the contract for the group plan.
5. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the group plan if premiums are not paid timely. I authorize my Employer to withhold payments from my wages as contribution to the premium, as appropriate.

Misrepresentation

6. 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.