New Jersey Business (51 - 100 Eligible Employees) Employee Enrollment/Change Form

Life, Accidental Death & Personal Loss, Disability, Aetna Managed Choice and Aetna Indemnity plans are underwritten by Aetna Life Insurance Company. The In-network component of our Savings Plus Health Network Option plans are underwritten by Aetna Health Inc. The Out-of-Network component of our Savings Plus Health Network Option plans is underwritten by Aetna Health Insurance Company. DMO and Voluntary DMO coverage is underwritten by Aetna Dental Inc. Aetna Life Insurance Company provides all other dental coverage.

INSTRUCTIONS: You, the employee, must complete this enrollment form in full or it will be returned to you resulting in a delay in processing. You are solely responsible for its accuracy and completeness. If waiving coverage, please complete Sections B and G.

Member Aetna ID Number (if available)

Company Name

Effective Date / Date of Hire				
	☐ New Hire ☐ Rehire/Reinstatement ☐ New Group Enrollment ☐ Late Enrollment ☐ Other _____	☐ Change of Coverage ☐ Add Spouse/Civil Union/ Domestic Partner ☐ Add Dependent Child ☐ Name Change ☐ Other _____	☐ Employee Termination ☐ Remove Spouse/ Civil Union/ Domestic Partner ☐ Remove Dependent Child ☐ Cancel Coverage	☐ COBRA for: ☐ Employee ☐ Dependent Length of Continuation: ☐ 18 ☐ 36 ☐ Other ____ Original Qualifying Event Date _____ Reason _____

A. Coverage Selection – *Please print clearly, using black ink. (Shaded sections for Employer/Aetna Use Only)*

Control/Group No.	Suffix	Account	Plan No.	Class Code

1. Health Benefits
   - ☐ NJ Savings Plus Health Network Option – Plan Option: _____
   - ☐ NJ Managed Choice (MC) – Plan Option _____
   - ☐ NJ Open Access® Managed Choice (OA MC) – Plan Option _____
   - ☐ NJ Open Access® Managed Choice (OA MC) HSA Compatible – Plan Option _____

   Plan Administration: ☐ Calendar Year ☐ Plan Year
   - ☐ NJ Indemnity

Control/Group No.	Suffix	Account	Plan No.	Class Code

2. Dental Benefits

Standard Plans: Option: _____ *FOC:* ☐ DMO® *or* ☐ PPO

Voluntary Plans: Option: _____ *FOC:* ☐ DMO® *or* ☐ PPO

Before today, were you covered under this employer's dental plan? ☐ Yes ☐ No

Control/Group No.	Suffix	Account	Plan No.

3. Life and Disability* Benefits A separate Evidence of Insurability form may be required for life or disability coverage.

☐ Basic Life/AD&D Ultra® ☐ Optional Dependent Life ☐ Short Term Disability* ☐ Life & Disability* Packaged Plan

* Disability coverage is not available for dependents.

Full Beneficiary Name (First, Middle, Last)	Beneficiary Social Security Number	Birthdate (MM/DD/YYYY) / /

Beneficiary Address (Number, Street, Apt. No., City, State, ZIP Code)	Telephone Number ( ) -	Relationship to Employee

B. Employee Information – *Must be completed by the employee.*

Social Security Number	Last Name, First Name, M.I.	Primary Language Spoken (optional)

Home Address	Apt. No.	City, State	ZIP Code
Work Address		**City, State**	**ZIP Code**

Home Telephone ( ) -	Work Telephone ( ) -	No. of Hours Worked Per Week	Number of Dependents (including Spouse/ Civil Union/Domestic Partner)

Salary $		Check One	Check One
	☐ Hourly ☐ Weekly ☐ Monthly	☐ Full-Time ☐ 1099 ☐ Union ☐ Seasonal ☐ Part-Time ☐ Retiree ☐ COBRA ☐ Temporary	☐ Married ☐ Civil Union Partner ☐ Single ☐ Domestic Partner

C. Individuals Covered - *List individuals for whom you are enrolling or adding/changing/removing coverage. Attach additional sheets if necessary.* Disability coverage is not available for dependents. If a coverage does not apply, please ✓ N/A in the appropriate box.
NOTE FOR MEDICAL AND SOME DENTAL COVERAGE: While the Federal Patient Protection and Affordable Care Act mandates coverage of dependent children up to age 26, your plan may allow coverage beyond age 26. Some exceptions apply. Please refer to your plan documents or contact your benefits administrator.

1	(A)dd (C)hange (R)emove ___	Employee Name (Last, First, M.I.)	Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /		
Disabled Yes ☐ N/A ☐	Coverage Election *(Check only Coverage(s) you are applying for)* ☐ Medical ☐ Dental ☐ Life/Disability	Primary Medical Office ID Number *(if applicable)* For Medical Only	Current Patient Yes ☐ N/A ☐	Dental Office ID Number *(if applicable)* For Dental Only	Current Patient Yes ☐ N/A ☐		
2	(A)dd (C)hange (R)emove ___	Name (Last, First, M.I.) ☐ Spouse ☐ Civil Union ☐ Domestic Partner	Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /		
Disabled Yes ☐ N/A ☐	Coverage Election *(Check only Coverage(s) you are applying for)* ☐ Medical ☐ Dental ☐ Life	Primary Medical Office ID Number *(if applicable)* For Medical Only	Current Patient Yes ☐ N/A ☐	Dental Office ID Number *(if applicable)* For Dental Only	Current Patient Yes ☐ N/A ☐		
3	(A)dd (C)hange (R)emove ___	Child Name (Last, First, M.I	Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /		
Disabled Yes ☐ N/A ☐	Coverage Election *(Check only Coverage(s) you are applying for)* ☐ Medical ☐ Dental ☐ Life	Primary Medical Office ID Number *(if applicable)* For Medical Only	Current Patient Yes ☐ N/A ☐	Dental Office ID Number *(if applicable)* For Dental Only	Current Patient Yes ☐ N/A ☐		
4	(A)dd (C)hange (R)emove ___	Child Name (Last, First, M.I	Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /		
Disabled Yes ☐ N/A ☐	Coverage Election *(Check only Coverage(s) you are applying for)* ☐ Medical ☐ Dental ☐ Life	Primary Medical Office ID Number *(if applicable)* For Medical Only	Current Patient Yes ☐ N/A ☐	Dental Office ID Number *(if applicable)* For Dental Only	Current Patient Yes ☐ N/A ☐		
5	(A)dd (C)hange (R)emove ___	Child Name (Last, First, M.I	Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /		
Disabled Yes ☐ N/A ☐	Coverage Election *(Check only Coverage(s) you are applying for)* ☐ Medical ☐ Dental ☐ Life	Primary Medical Office ID Number *(if applicable)* For Medical Only	Current Patient Yes ☐ N/A ☐	Dental Office ID Number *(if applicable)* For Dental Only	Current Patient Yes ☐ N/A ☐		
6	(A)dd (C)hange (R)emove ___	Child Name (Last, First, M.I	Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /		
Disabled Yes ☐ N/A ☐	Coverage Election *(Check only Coverage(s) you are applying for)* ☐ Medical ☐ Dental ☐ Life	Primary Medical Office ID Number *(if applicable)* For Medical Only	Current Patient Yes ☐ N/A ☐	Dental Office ID Number *(if applicable)* For Dental Only	Current Patient Yes ☐ N/A ☐		

D. Health Questionnaire – Complete for:

- A virgin group with no medical coverage;
- A newly formed business with no group medical coverage;
- Requesting life coverage above the Guarantee Issue amount; or
- A Late Enrollee (enrolling more than 31 days after eligible).

Health History for Employees and your Dependents.

- ALL of the questions must be answered by you and your dependents or the enrollment form will be returned.
- Incomplete enrollment forms may delay the effective date of your coverage.

NOTE: Before submitting this completed form to your employer, you may wish to protect the confidentiality of your health information by taping or stapling the form so Pages 3 is not visible.

List all individuals enrolling for coverage. Name	Sex	Age	Height	Weight	Cigarette Smoker	Currently Taking Prescription Medication(s)
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No

E. Answer all questions.

1. Within the last **five** years has anyone applying for coverage consulted, received treatment, by a doctor, psychiatrist, psychologist, or other practitioner or been diagnosed with any of the following conditions or disorders? (Check all that apply.) ☐ Yes ☐ No

a. ☐ AIDS/ARC/HIV
b. ☐ Diabetes
c. ☐ Infertility
d. ☐ Endocrine/Metabolic
e. ☐ Pancreas
f. ☐ Liver/Hepatitis
g. ☐ Immune System
h. ☐ Blood Disorder
i. ☐ Hemophilia
j. ☐ Epilepsy/Seizure
k. ☐ Heart Disorder/ Disease
l. ☐ Paralysis/Paresis
m. ☐ Tumor/Cyst/Growth
n. ☐ Systemic or Discoid Lupus
o. ☐ Lung or Respiratory
p. ☐ Alcohol or Drug Use
q. ☐ Kidney/Bladder/Urinary
r. ☐ Circulatory/Vascular
s. ☐ Digestive/Stomach/Intestinal
t. ☐ Central Nervous System
u. ☐ Connective Tissue Disorder
v. ☐ Pituitary/Adrenal/Growth Disorder
w. ☐ Birth Defects/Congenital Abnormalities
x. ☐ Arthritis/Bone/Joint/Muscle/Prosthetic Device
y. ☐ Mental/Nervous/Emotional/Eating Disorder
z. ☐ Stroke/Brain/Neurological
aa. ☐ Transplant: ☐ Recommended ☐ Pending ☐ Complete
bb. ☐ Advised to have ☐ tests, ☐ surgery, ☐ hospitalization or is ☐ treatment needed, or ☐ course of treatment not yet determined
cc. ☐ Cancer: Type:_____ Stage _____ ☐ Surgery ☐ Chemo ☐ Radiation
dd. ☐ Using: ☐ Crutches ☐ Walker ☐ Wheelchair
ee. ☐ Other _____

2. Is any female currently pregnant? If so, provide due date _____ Check applicable boxes: ☐ C section planned ☐ Multiple Births expected (# _____) ☐ Complications: ☐ Past or ☐ Present ☐ Yes ☐ No
3. Has anyone applying for coverage incurred medical expenses in excess of $5,000 in the past 24 months? ☐ Yes ☐ No
4. Has anyone applying for coverage been prescribed medications in the past 12 months? ☐ Yes ☐ No
5. Does anyone applying for coverage have a known condition that requires on-going treatment? ☐ Yes ☐ No

F. Provide details below to any boxes checked above. *(If additional space is needed, attach a separate sheet and be sure to sign and date the sheet.)*

Ques. No.	Name of Individual	Condition/Diagnosis/ Treatment	Date of Onset	Date Treatment Ended	Names of Prescription Medication	Dosage	Still Taking Medication
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

G. Declination/Waiver of Coverage - *To be completed if medical and/or dental coverage is declined or refused by an eligible employee and/or their eligible family members.*

1. Medical Coverage Declined for: ☐ Myself ☐ Dependents ☐ Spouse/Civil Union/Domestic Partner 2. Dental Coverage Declined for: ☐ Myself ☐ Dependents ☐ Spouse/Civil Union/Domestic Partner	Reason for Declining Coverage *(If applicable, please attach front/back of your health coverage ID card.)* ☐ Covered by Spouse/Civil Union/Domestic Partner's group coverage - Carrier Name and ID Number _____ ☐ Enrolled in another Medical or Dental Plan – Carrier Name and ID: _____ ☐ Medicare ☐ Covered by TRICARE or CHAMPVA ☐ Other (Explain): _____ ☐ Spouse/Civil Union/Domestic Partner covered by employer's group medical coverage ☐ Spouse/Civil Union/Domestic Partner covered by employer's group dental coverage

I was given the opportunity to enroll in these plans of medical, group life, disability, and dental benefits offered by my employer and underwritten by Aetna Life Insurance Company, Aetna Health Insurance Company, Aetna Health Inc., and Aetna Dental Inc.; however, I refuse the above coverage(s). By declining this group coverage I acknowledge that I and/or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage.

Please sign here ONLY if you are declining coverage for yourself or your dependent(s). X Employee Signature	*Date (Month/Day/Year)*

H. Dependent Information

Does any dependent listed in Section C live at another address? ☐ Yes ☐ No If "Yes," who and what address?

For Dependent Life Coverage: If age 19 and over and a full-time student, provide the following:

Child Name	School Name	Expected Graduation Date	Number of Credit Hours

I. Coordination of Benefits

Will you have other health insurance at the same time as this coverage? ☐ Yes ☐ No

Name of Person	Carrier Name	Name of Person	Carrier Name

If you have questions concerning the benefits and services provided by or excluded under this Plan, contact a Member Services representative at 1-877-350-2217 (for Health Network Option products) or 1-888-802-3862 (for Indemnity or MC products) before or after signing this form.

J. 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. and/or Aetna Health Insurance Company and/or Aetna Life Insurance Company, and/or Aetna Dental Inc. or any consumer reporting agency acting on its behalf, 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 consumer reporting agency; any employer. Please note that a consumer report includes information regarding the enrollee's character, general reputation, personal characteristics, and mode of living. If you would like a copy of your consumer report obtained by Aetna, you may contact Member Services. Aetna will provide a copy of the report upon request.
   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. and/or Aetna Health Insurance Company and/or Aetna Life Insurance Company and/or Aetna Dental 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 this authorization is as valid as the original.
2. I acknowledge by enrolling in an Aetna plan, coverage is provided by Aetna Health Inc. and/or Aetna Health Insurance Company and/or Aetna Life Insurance Company and/or Aetna Dental 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. and/or Aetna Health Insurance Company and/or Aetna Life Insurance Company and/or Aetna Dental 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 Life or Health benefits plan is subject to criminal and civil penalties.

K. Employee Signature

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

Employee Signature - Required	*Employee E-mail Address (optional)*	*Date (Month/Day/Year)*
X		

L. Employer Verification – To be completed by Employer

Employer Signature – Required	*Title*	*Date (Month/Day/Year)*
X		

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

Instructions

Employer

- Complete the **Employer Group Information** at the top of the form.
- Complete **Section L - 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.

Employee – Complete Sections A - K

Section A – Coverage Selection

- Check one plan option box for each coverage that is offered by your employer.
- **Medical** - Check one Plan Option box and indicate Plan Option name (where applicable).
- **Dental** – Enter Plan Option and FOC selection (if applicable).
- **Life/Disability** – Check applicable boxes. Complete all requested Beneficiary information.

Section B - Employee Information: Complete **all** information in order for your application to be processed.

Section C - Individuals Covered:

- Do not complete this form 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.
- 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, Social Security Number and Birthdate for each individual listed.
- If dependent is disabled and being continued beyond the limiting age, attach proof of disability.
- From the appropriate provider 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.
- If you are a current patient, check the "Current Patient" box(es) that apply.

Sections D, E and F – Health Questionnaire: Complete for a virgin group with no group medical coverage; a newly formed business with no group medical coverage; requesting life coverage above the Guarantee Issue amount; or a Late Enrollee (enrolling more than 31 days after eligible).

Section G – Declination/Waiver of Coverage: Complete this section if declining coverage for any eligible employee and/or their eligible family members. Employee must sign and date.

Section H – Dependent Information: Complete this section for all new enrollments or coverage changes.

Section I – Coordination of Benefits: Complete this section for all new enrollments or coverage changes.

Section J – Conditions of Enrollment: Please read carefully.

Section K – 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.

Section L – 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.