aetna℠

New Jersey Employee Enrollment/Change Request

For Employer Groups with 101 or More Employees

Aetna Health Inc. / Aetna Health Insurance Company

Aetna HMO plans, Aetna Health Network Only plans and the In-network component of our POS and Health Network Option plans are underwritten by Aetna Health Inc. The Out-of-Network component of our POS and Health Network Option plans is underwritten by Aetna Health Insurance Company.

Member Aetna ID Number (if available)

Employer Name	**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 C and G.**

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 4 before completing this form. Please print clearly.***

1. Enrollment

- ☐ New Hire
- ☐ Rehire/Reinstatement
- ☐ New Group Enrollment
- ☐ Late Enrollment
- ☐ Other _____

Effective Date ___/___/___

Date of Hire ___/___/___

2. Change – *Check all that apply.*

	Date of Event	Reason
☐ Change of Coverage	___/___/___	
☐ Add Spouse/Civil Union/ Domestic Partner/Dependent Child	___/___/___	
☐ Name Change	___/___/___	
☐ Other	___/___/___	
☐ Add/Change Primary Office ID Number or NPI Number	___/___/___	

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

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

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

NOTE: Employee must be enrolled for spouse/civil union/domestic 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.*

☐ COBRA ☐ State Continuation ☐ Total Disability

Coverage for:
☐ Employee ☐ Spouse/Civil Union/Domestic Partner* ☐ Dependent(s)

Length of Continuation: ☐ 18 mos. ☐ 29 mos. ☐ 36 mos.
☐ Total Disability – Attach proof of total disability

Date of Loss of Coverage: ___/___/___

Date of Qualifying Event: ___/___/___

Reason: _____

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

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

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

Check One.

- ☐ HMO – Plan Option: _____
- ☐ QPOS® – Plan Option: _____
- ☐ Aetna Open Access® HMO – Plan Option: _____
- ☐ Aetna Choice® POS – Plan Option: _____
- ☐ AHF Choice® POS – Plan Option: _____
- ☐ Aetna Health Network Option℠ – Plan Option: _____
- ☐ Aetna Health Network Only℠ – Plan Option: _____

Available option with Aetna Health Network Option and Aetna Health Network Only:

☐ Aetna HealthFund®

Primary Copay:

☐ $5 ☐ $10 ☐ $15 ☐ Other _____

C. Employee Information - ***Must be completed by the employee.***

Social Security Number	Last Name, First Name, M.I.		Home Telephone	Primary Language Spoken (Optional)
Home Address	Apt. No.	City, State		ZIP Code
Work Address	City, State		ZIP Code	Work Telephone

Salary $	☐ Hourly ☐ Weekly ☐ Monthly	No. of Hours Worked Per Week	Check One: ☐ Full-Time ☐ Part-Time ☐ 1099 ☐ Retired ☐ Seasonal ☐ Temporary ☐ COBRA ☐ Union	Marital Status ☐ Married ☐ Single ☐ Civil Union Partner ☐ Domestic Partner	No. of Dependents Including Spouse/Civil Union/ Domestic Partner

D. Individuals Covered - ***List individuals for whom you are enrolling or adding/changing/removing coverage. Attach additional sheets if necessary.***

NOTE: 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.

(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex M/F	Social Security Number	Birthdate MM DD YYYY	Disabled	Other Medical Coverage	Other Rx Drug Coverage	Out of Area	Primary Office ID Number (if applicable) / NPI Number	Current Patient	Previous Coverage Check if "Yes"
	1. Employee				Yes N/A	Yes ☐	Yes ☐	Yes ☐	Office / NPI	Yes ☐	Yes ☐
	2. Spouse/Civil Union/Domestic Partner				N/A	☐	☐	☐	Office / NPI	☐	☐
	3. Child				☐	☐	☐	☐	Office / NPI	☐	☐
	4. Child				☐	☐	☐	☐	Office / NPI	☐	☐

E. Pre-Existing Conditions Statement – Check all that apply.

NOTE: Complete for all persons to be covered who are age 19 or older. This section does not apply to any person who is under age 19. Complete if you are a new enrollee. Complete for all late enrollees. This information may **ONLY** be used to determine if a condition is a pre-existing condition. You **CANNOT** be denied coverage under a health benefits plan on the basis of accurate responses to the following questions. Carriers can only use the information to expedite the processing of claims.

Yes	No	
☐	☐	1. During the past 6 months, have you or any dependent to be covered who is age 19 or older had or been diagnosed as having any of the following? If "Yes," check appropriate box(es) below.

☐ a. Alcoholism or Drug Abuse
☐ b. Arthritis
☐ c. Blood Disorder
☐ d. Back or Neck Disorder, Injury
☐ e. Cancer or Tumors
☐ f. Diabetes
☐ g. Gastro or Intestinal Disorder
☐ h. Heart Disorder or Condition or Chest Pain
☐ i. High Blood Pressure
☐ j. Kidney or Liver Disorder
☐ k. Lung or Respiratory Disorder or Pain
☐ l. Mental or Nervous Disorder
☐ m. Paralysis, Stroke or Epilepsy

Yes	No	
		2. During the past 6 months, have you or any dependent to be covered who is age 19 or older:
☐	☐	a. been examined or treated by a physician or other health care provider for any condition, illness, or injury, other than as stated above?
☐	☐	b. been advised to have treatment or surgery or testing that has not been done?
☐	☐	c. been admitted to a hospital or other health care facility as an inpatient?
☐	☐	d. taken prescribed medications?

Please give details for "Yes" answers to any part of Questions 1 or 2 on a separate sheet of paper. This separate sheet should be signed and dated.

F. Race/Ethnicity – Optional (This information is designed for the purpose of data collection and will not be used for determining eligibility, rating or claim payment.)

Employee 1. ☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latin – 03 ☐ Asian – 04 ☐ Other – 05 _____

Spouse/Civil Union/Domestic Partner 2. ☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latin – 03 ☐ Asian – 04 ☐ Other – 05 _____

Child 3. ☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latin – 03 ☐ Asian – 04 ☐ Other – 05 _____

Child 4. ☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latin – 03 ☐ Asian – 04 ☐ Other – 05 _____

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.***

Coverage Declined for: ☐ Myself ☐ Dependents ☐ Spouse/Civil Union/Domestic Partner

Reason for Declining Coverage *(If applicable, please attach front/back of your coverage ID card.)***:**

☐ Covered by Spouse's/Civil Union/Domestic Partner's group coverage - Carrier Name and ID Number _____

☐ Enrolled in another Medical 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 the medical plan offered by my employer and underwritten by Aetna Health Inc. and Aetna Health Insurance Company; 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).	***Date (Month/Day/Year)***
X Employee Signature	

H. Dependent Information

Does any dependent listed in Section **D** live at another address? ☐ Yes ☐ No If "Yes," who and what address?	If any dependent's last name differs from yours, explain the circumstances.

I. Other/Previous Medical Coverage

If you have checked "Yes" to Other Medical or Rx Drug Coverage (Section C), provide name and policy number of carrier, HMO, or other source, a copy of the ID card, and start date of the coverage.

If enrolling your Spouse/Civil Union/Domestic Partner, are they employed? ☐ Yes ☐ No If "Yes," provide name and address of Spouse's/Civil Union/Domestic Partner's employer.

PROOF OF PRIOR MEDICAL COVERAGE – IMPORTANT *(Required)*

Does anyone age 19 or over enrolling on this enrollment form have prior coverage? ☐ Yes ☐ No

If "Yes," provide the information requested in the table below.

Proof of coverage should accompany this enrollment form for pre-existing condition credit if enrolling in other than an HMO plan. **Acceptable forms of proof are:**

1. Certificate of Creditable Coverage from prior carrier, or
2. Copy of ID card or most recent payroll stub showing medical coverage deduction, or
3. Copy of most recent medical premium bill from prior carrier.

Failure to provide Proof of Prior Coverage may subject you or a family member (age 19 or over) to the full pre-existing conditions limitation with no credit for prior coverage. You may request a Certificate of Creditable Coverage from your prior carrier.
NOTE: If your Plan contains a pre-existing conditions provision, the pre-existing conditions exclusion and limitation will not apply to a person under 19 years of age.

Name of Covered Individual	Carrier Name	Group Number	Start Date	Termination Date	Medical
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

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

J. Conditions of Enrollment

Applicant Acknowledgments and Agreements

On behalf of myself and the dependents listed in Section D, 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 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 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 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.
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 medical 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. or Aetna Health Insurance Company prior to visiting a specialist or admission to a hospital.

Please make a copy for your records. Visit us at www.aetna.com.

NOTE: 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.

Instructions

Employer

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

Employee – Complete Sections A – K

Section A – Type of Activity:

- Check boxes indicating reason(s) for submitting application.
- Employee must complete this section for all new enrollments, coverage changes and terminations.
- Employer must sign and date **Section L** of this Enrollment/Change Request form in order for it to be processed.

Section B – Medical Plan Options:

- Check one plan option box, indicate Plan Option Name (where applicable) and check ***one*** Copay.
- Select only an option offered by your employer.

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

Section D – 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.
- If you or your dependent(s) have other Medical or Rx drug coverage, check off the "Yes" box(es) and complete Section I - Other/Previous Medical Coverage.
- 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.
- 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.
- If you had previous coverage, please check the “Previous Coverage” box.

Section E – Pre-Existing Conditions Statement: Complete this section for all new enrollments for persons who are age 19 or older. This section does not apply to any persons who are under age 19.

Section F – Race/Ethnicity (Optional): Check the appropriate Race/Ethnicity code for each individual. If your Race/Ethnicity is “Other,” print the Race/ Ethnicity for each individual in the space provided.

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 – Other/Previous Medical Coverage: Complete this section for all new enrollments or coverage changes. Coverage includes group coverage, HMO, governmental coverage, a church plan or Medicare.

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.