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

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	/ /	
☐ Add Domestic Partner	/ /	
☐ Add Dependent Child	/ /	
☐ Name Change	/ /	
☐ Change Plan	/ /	
☐ Other	/ /	
☐ Add/Change Office ID Numbers: Primary		

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

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

NOTE: Employee must be enrolled for spouse/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 ☐ Dependents

Length of Continuation: ☐ 12 mos ☐ 18 mos ☐ 29 mos ☐ 36 mos ☐ Total Disability*

Date of Loss of Coverage: ___/___/___

Date of Qualifying Event: ___/___/___

*Attach proof of total disability.

B. Employee Information - Complete Sections B - H.

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. Plan Option - Your selection must be offered by your employer.

1. Medical - Check One:

☐ NJ HMO: Plan Option - ______ Suffix *(please circle one)*: N or S

☐ NJ HMO No-Referral: Plan Option - ______ Suffix *(please circle one)*: N or S

☐ NJ Cost-Sharing HMO: Plan Option - ______ Suffix *(please circle one)*: N or S

☐ NJ POS No-Referral: Plan Option - ______ Suffix *(please circle one)*: N or S

☐ NJ PPO Basic Hospital Plan

☐ NJ PPO First Dollar Plan

☐ Out-of-State/SitusPPO: ☐ $250 (High) ☐ $500 (Medium) ☐ $1,000 (Low)

☐ Standard Health Benefits Plans:

- NJ HMO: ☐ $5 Plan ☐ $10 Plan ☐ $15 Plan ☐ $20 Plan ☐ $30 Plan
  ☐ With RX Rider ($15/$25/$40)
  ☐ Without RX Rider (50%)
- NJ Indemnity: ☐ Plan A1 ☐ Plan A2 ☐ Plan B ☐ Plan C ☐ Plan D ☐ Plan E1 ☐ Plan E2

☐ Other Plan ______

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 Rx Drug Coverage	Other Health Coverage	Previous Coverage Check if "Yes"	Primary Office ID Number	Current Patient
Employee			☐ ☐	/ /		Yes ☐	Yes ☐	Yes ☐		Yes ☐
Spouse			☐ ☐	/ /		☐	☐	☐		☐
Domestic Partner			☐ ☐	/ /		☐	☐	☐		☐
Child			☐ ☐	/ /		☐	☐	☐		☐
Child			☐ ☐	/ /		☐	☐	☐		☐
Child			☐ ☐	/ /		☐	☐	☐		☐

E. Pre-Existing Conditions Statement

NOTE: 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 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:
- ☐ ☐ 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. Other/Previous Insurance

Is your Spouse Employed? ☐ Yes ☐ No If "Yes," give name & address of spouse'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.

G. 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.

H. Employee Signature

If you have questions concerning the benefits and services provided by or excluded under this Agreement, contact a Member Services representative at 1-800-702-3862 (for HMO or POS products) or 1-888-802-3862 (for Traditional/PPO products) before or after signing this form.

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 the employee copy of this Enrollment/Change Request Form. I authorize deductions from my earnings for any required contributions.

Employee Signature - *Required*	E-Mail Address	Date
X		/ /

I. Employer Verification - To Be Completed by Employer

Employer Signature - *Required*	Title	Date
X		/ /

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 I - 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 Form in order for it to be processed.

Employee - Complete Sections B - H.

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

Section C - Plan Option:
- 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:
- 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 F - Other/ Previous Insurance.
- 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, please check the "Current Patient" box.

Section E - Pre-Existing Conditions Statement:
Complete this section for all new enrollments. **Exceptions** for Small Employer Group coverage, this section must be completed only by persons enrolling for coverage in a group of 2 - 5 employees, and by late entrants.

Section F - 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 G - Dependent Information:
Complete this section for all new enrollments or coverage changes.

Section H - 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 I - 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 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 Life 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.
   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 Life 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 Life 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 Life 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 health benefits plan is subject to criminal and civil penalties.