New Jersey Small Group Enrollment/Change Request

Aetna Health Inc. / Aetna Life Insurance Company

Aetna HMO, HNOnly, HNOption and QPOS plans are underwritten by Aetna Health Inc. Aetna Indemnity, OA EPO, OA MC 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 4 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 Section D for each member being removed or terminated.

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: ___/___/___

Qualifying Event #: _____ ***

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

** Attach proof of disability.

*** Refer to list of qualifying event numbers on Page 4-Instructions section.

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 Aetna Whole Health (AWH) OA EPO: Plan Option: _____

☐ 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/continuing coverage. Attach sheet to list additional children. Attach proof of disability.**

1

☐ Add ☐ Remove ☐ Continuation ☐ Other

Employee Name (Last, First, M.I.)	Sex (M/F)	Birthdate (MM/DD/YYYY)
If a name change, indicate prior name:		/ /

Primary Office ID Number	NPI Number	Current Patient ☐ Yes ☐ No	Primary Care Provider Name

Primary Office Address/Location	ZIP Code +4

Other Health Coverage ☐ Yes ☐ No ***If yes*:**
Payer Name: _____
Policy Number: _____
Medicare ID Number, if any: _____

Other Rx Coverage ☐ Yes ☐ No ***If yes*:**
Payer Name: _____
Policy Number: _____
Medicare ID Number, if any: _____

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☐ Add ☐ Remove ☐ Other ☐ Continue Spouse ☐ Continue Civil Union Partner (NJSGC)

Name (Last, First, M.I.) ☐ **Spouse** ☐ **Domestic Partner** ☐ **Civil Union Partner**	Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY)
			/ /

Primary Office ID Number	NPI Number	Current Patient ☐ Yes ☐ No	Primary Care Provider Name

Primary Office Address/Location	ZIP Code +4

Other Health Coverage ☐ Yes ☐ No ***If yes*:**
Payer Name: _____
Policy Number: _____
Medicare ID Number, if any: _____

Other Rx Coverage ☐ Yes ☐ No ***If yes*:**
Payer Name: _____
Policy Number: _____
Medicare ID Number, if any: _____

3

☐ Add ☐ Remove ☐ Continuation ☐ Other

Name (Last, First, M.I.) ☐ **Child**	Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY)
			/ /

Primary Office ID Number	NPI Number	Current Patient ☐ Yes ☐ No	Primary Care Provider Name

Primary Office Address/Location	ZIP Code +4

Other Health Coverage ☐ Yes ☐ No ***If yes*:**
Payer Name: _____
Policy Number: _____
Medicare ID Number, if any: _____

Other Rx Coverage ☐ Yes ☐ No ***If yes*:**
Payer Name: _____
Policy Number: _____
Medicare ID Number, if any: _____

4

☐ Add ☐ Remove ☐ Continuation ☐ Other

Name (Last, First, M.I.) ☐ **Child**	Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY)
			/ /

Primary Office ID Number	NPI Number	Current Patient ☐ Yes ☐ No	Primary Care Provider Name

Primary Office Address/Location	ZIP Code +4

Other Health Coverage ☐ Yes ☐ No ***If yes*:**
Payer Name: _____
Policy Number: _____
Medicare ID Number, if any: _____

Other Rx Coverage ☐ Yes ☐ No ***If yes*:**
Payer Name: _____
Policy Number: _____
Medicare ID Number, if any: _____

continued on next page

D. Individuals Covered (Continued)

5

☐ Add ☐ Remove ☐ Continuation ☐ Other

Name (Last, First, M.I.) ☐ **Child**	Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /

Primary Office ID Number	NPI Number	Current Patient ☐ Yes ☐ No	Primary Care Provider Name

Primary Office Address/Location	ZIP Code +4

Other Health Coverage ☐ Yes ☐ No ***If yes*:**
Payer Name: _____
Policy Number: _____
Medicare ID Number, if any: _____

Other Rx Coverage ☐ Yes ☐ No ***If yes*:**
Payer Name: _____
Policy Number: _____
Medicare ID Number, if any: _____

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☐ Add ☐ Remove ☐ Continuation ☐ Other

Name (Last, First, M.I.) ☐ **Child**	Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /

Primary Office ID Number	NPI Number	Current Patient ☐ Yes ☐ No	Primary Care Provider Name

Primary Office Address/Location	ZIP Code +4

Other Health Coverage ☐ Yes ☐ No ***If yes*:**
Payer Name: _____
Policy Number: _____
Medicare ID Number, if any: _____

Other Rx Coverage ☐ Yes ☐ No ***If yes*:**
Payer Name: _____
Policy Number: _____
Medicare ID Number, if any: _____

E. Additional Spouse/Civil Union Partner/Domestic Partner Information – *If not applicable, please mark as "NA."*

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

F. Additional Child Information

List any child who lives at a different address from the employee. If multiple children live at the same address, you may list them together.

Name	**Address**	**Reason**

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

List any dependent child who is incapacitated and over age 26. Additional forms will need to be completed by you and your child's doctor.

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

H. Employee Signature

I represent that all information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/ Change Request form. I authorize deductions from my earnings for any required contributions.

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

I. Employer Verification (To Be Completed by Employer) The requested activity is believed eligible and is approved by the Employer.

Employer Signature - *Required*	Title	Date
X		

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.

Instructions

Employer: You must complete the Employer Group Information and Sections A and I in order for this application to be processed.

Employee: You must complete Sections B through H.

- Please PRINT except when a signature is requested.
- If a dependent is disabled and you want to continue his or her coverage beyond age 26, you do not have to make a COBRA/NJSGC or Dependent Under 31 election. Instead, select "Other" in Section A2, and attach proof of disability.
- For provider addresses, include the zip code plus the four digit extension.
- You can obtain each provider's correct name, address and 6-digit office ID number for the primary care physician from the appropriate directory. Indicate office ID number selection(s) on the form.
- You can obtain the 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.
- **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.**

Qualifying Events

COBRA and NJSGC

C1. Termination of job or reduction in hours.
C2. Employee enrollment in Medicare (COBRA only)
C3. Divorce (COBRA/NJSGC); civil union dissolution (NJSGC)
C4. Death of employee
C5. Loss of dependent child status under the plan
C6. Disability (occurring subsequent to another qualifying event)