New Jersey Small Group Life, Disability, Vision, and Dental Enrollment/Change Request

Aetna Dental Inc. / Aetna Life Insurance Company

Life, Accidental Death and Personal Loss Coverage (AD&D Ultra®), Disability, and Aetna Vision℠ Preferred plans are underwritten by Aetna Life Insurance Company. DMO and Voluntary DMO coverage is underwritten by Aetna Dental Inc. All other dental coverage is provided by Aetna Life Insurance Company. For Vision coverage, certain claims administration services are provided by First American Administrators, Inc. and certain network administration services are provided through EyeMed Vision Care, LLC ("EyeMed").

Employer Group Information – To Be Completed by Employer

Group Name			
Life/AD&D Ultra® – Control No.	**Suffix**	**Account No.**	**Plan No.**
LTD – Control No.	**Suffix**	**Account No**	**Plan No.**
Dental – Control No.	**Suffix**	**Account No.**	**Plan No.**
Vision – Control No.	**Suffix**	**Account No.**	**Plan No.**

A. Type of Activity – To Be Completed by Employer. *Refer to instructions on Page 5 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 Same Sex Spouse	___/___/___	
☐ Add Dependent Child	___/___/___	
☐ Name Change	___/___/___	
☐ Change Plan	___/___/___	
☐ Other	___/___/___	
☐ Add/Change Primary Dentist Office ID Number	___/___/___	

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

	Effective Date	**Reason**
☐ Remove Spouse/Civil Union Partner*	___/___/___	
☐ Remove Domestic Partner*	___/___/___	
☐ Remove Same Sex Spouse*	___/___/___	
☐ Remove Dependent Child*	___/___/___	
☐ Employee Withdrawal/Termination	___/___/___	

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

* Please complete Section D for each member being removed or terminated.

4. COBRA Dental, Total Disability – *Not all options are available or applicable. Contact Employer for available options.*

COBRA Dental Coverage for: ☐ Employee ☐ Spouse/Civil Union Partner ☐ Domestic Partner ☐ Same Sex Spouse ☐ Dependent Child(ren)

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

Date of Loss of Coverage: ___/___/___ Date of Qualifying Event: ___/___/___ Qualifying Event #: _____ **

* Attach proof of disability.

** Refer to list of qualifying event numbers on Page 5 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. Coverage Selection – *Please print clearly, using black ink.*

1. Life and Disability ☐ Yes ☐ No

Life/AD&D Ultra® (for groups with 2-9 employees) *Check applicable boxes.*

☐ **Employee** Basic Life/AD&D Ultra®

Life/AD&D Ultra® (for groups with 10-50 employees) *Check applicable boxes.*

☐ **Employee** ☐ Basic Life/AD&D Ultra® ☐ Supplemental Life/ AD&D Ultra®

☐ **Spouse/Civil Union Partner/Domestic Partner/Same Sex Spouse**

☐ **Optional Spouse/Civil Union Partner/Domestic Partner/Same Sex Spouse** Life/AD&D Ultra®

☐ **Child** ☐ Optional Child Life/AD&D Ultra®

DESIGNATION OF BENEFICIARY – Carefully review Additional Conditions and Instructions for Designation of Beneficiary on Page 6.

Life Products require the employee to designate a beneficiary for benefits. A beneficiary is the person or entity who will receive the benefit payment. A primary beneficiary will be the first to receive the benefit. A contingent beneficiary will only receive the benefit payment if the primary beneficiary dies or is no longer available. The employee is automatically the primary beneficiary for dependent life and accidental death and personal loss coverage (AD&D Ultra®) benefits.

Beneficiary For:	**Full Name(s) or Entity (Trust or Estate)**	**Date of Birth**	**Social Security Number / Tax ID Number**	**Address** (Number, Street, Apt. No., City, State, ZIP Code)	**Phone**	**Relationship to Employee**	**% of Benefit** (must equal 100%)
Basic Life/ AD&D Ultra® Primary							
Basic Life/ AD&D Ultra® Contingent							
Supplemental Life/ AD&D Ultra® Primary							
Supplemental Life/ AD&D Ultra® Contingent							

SPOUSAL/CIVIL UNION PARTNER/DOMESTIC PARTNER/SAME SEX SPOUSE CONSENT FOR COMMUNITY PROPERTY STATES – See Additional Conditions and Instructions for Designation of Beneficiary Section on Page 6.

Please note that an Employee is under no obligation to complete the Spousal/Civil Union Partner/Domestic Partner/Same Sex Spouse Consent section on this form.

I am aware that my spouse/civil union partner/domestic partner/same sex spouse, the Employee named above, has designated someone other than me to be the beneficiary of group Life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior spousal/civil union partner/domestic partner/same sex spouse consent or waiver under this plan.

Spouse/Civil Union Partner/Domestic Partner/Same Sex Spouse Signature _____

Date _____

Disability – (*Coverage for **Employee** only)* *Check applicable box.*

Long Term Disability (for groups with 10-50 employees) ☐ Yes ☐ No

2. Vision (if applicable) ☐ Yes ☐ No

Aetna Vision Preferred ☐ Yes ☐ No *Check applicable box.*

C. Coverage Selection – *Continued*

3. Dental ☐ Yes ☐ No *Enter plan number and name below.*

Contributory (Non-Voluntary) Plans:
Plan Number: _____
Plan Name: _____
If FOC, check: ☐ DMO® *or* ☐ PPO

Voluntary Plans:
Plan Number: _____
Plan Name: _____
If FOC, check: ☐ DMO® *or* ☐ PPO

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

Creditable coverage is allowed for new members enrolling in voluntary takeover groups. New hires please see below if applicable:

New Hire selecting a Voluntary Plan **and your Aetna plan is a takeover group**: Were you covered for 12 months under a dental plan within the last 90 days that included both Preventive and Basic coverage? Discount dental and preventive only plans do not apply. ☐ Yes ☐ No

D. Individuals Covered – List individuals for whom you are adding/changing/removing/continuing coverage. Attach sheet to list additional children.

1

Type of Activity: ☐ Add ☐ Remove ☐ Continuation ☐ Other
Coverage Election: ☐ Dental ☐ Vision ☐ Life/AD&D Ultra® ☐ LTD

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

Dentist Office ID Number	NPI Number	Current Patient ☐ Yes ☐ No	Dentist Provider Name
Dentist Office Address/Location			ZIP Code +4

Other Dental Coverage ☐ Yes ☐ No ***If yes*:**
Payer Name: _____ Policy Number: _____

2

Type of Activity: ☐ Add ☐ Remove ☐ Other
☐ Continue Spouse/Civil Union Partner ☐ Continue Domestic Partner ☐ Continue Same Sex Spouse
Coverage Election: ☐ Dental ☐ Vision ☐ Life/AD&D Ultra®

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

Dentist Office ID Number	NPI Number	Current Patient ☐ Yes ☐ No	Dentist Provider Name
Dentist Office Address/Location			ZIP Code +4

Other Dental Coverage ☐ Yes ☐ No ***If yes*:**
Payer Name: _____ Policy Number: _____

3

Type of Activity: ☐ Add ☐ Remove ☐ Continuation ☐ Other
Coverage Election: ☐ Dental ☐ Vision ☐ Life/AD&D Ultra®

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

Dentist Office ID Number	NPI Number	Current Patient ☐ Yes ☐ No	Dentist Provider Name
Dentist Office Address/Location			ZIP Code +4

Other Dental Coverage ☐ Yes ☐ No ***If yes*:**
Payer Name: _____ Policy Number: _____

continued on next page

D. Individuals Covered (Continued)

4

Type of Activity: ☐ Add ☐ Remove ☐ Continuation ☐ Other
Coverage Election: ☐ Dental ☐ Vision ☐ Life/AD&D Ultra®

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

Dentist Office ID Number	NPI Number	Current Patient ☐ Yes ☐ No	Dentist Provider Name

Dentist Office Address/Location	ZIP Code +4

Other Dental Coverage ☐ Yes ☐ No ***If yes*:**
Payer Name: _____ Policy Number: _____

5

Type of Activity: ☐ Add ☐ Remove ☐ Continuation ☐ Other
Coverage Election: ☐ Dental ☐ Vision ☐ Life/AD&D Ultra®

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

Dentist Office ID Number	NPI Number	Current Patient ☐ Yes ☐ No	Dentist Provider Name

Dentist Office Address/Location	ZIP Code +4

Other Dental Coverage ☐ Yes ☐ No ***If yes*:**
Payer Name: _____ Policy Number: _____

6

Type of Activity: ☐ Add ☐ Remove ☐ Continuation ☐ Other
Coverage Election: ☐ Dental ☐ Vision ☐ Life/AD&D Ultra®

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

Dentist Office ID Number	NPI Number	Current Patient ☐ Yes ☐ No	Dentist Provider Name

Dentist Office Address/Location	ZIP Code +4

Other Dental Coverage ☐ Yes ☐ No ***If yes*:**
Payer Name: _____ Policy Number: _____

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

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

If you wish to receive documents electronically, please refer to Aetna Navigator® at http://www.aetna.com/individuals-families/aetna-navigator.html.

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

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

Employer Signature - *Required* **X**	Title	Date

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 agree Aetna Dental Inc. and/or Aetna Life Insurance Company will provide coverage in accordance with the terms of the contract for the group plan.
2. 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.
- 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 dentist 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.

Qualifying Events

Dental COBRA

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

Additional Conditions and Instructions for Designation of Beneficiary

Conditions for Designation of Beneficiary

- **Please note:** The Group Contract grants the member the authority to designate a beneficiary. A beneficiary designated by someone other than the member (i.e., attorney-in-fact, Power of Attorney, guardian, custodian, etc.) may be barred under the Group Contract, by the Power of Attorney executed by the member and/or by state law. The member should execute the beneficiary designation section of this form whenever possible to ensure the designation is deemed valid.
- Unless otherwise expressly provided in the Designation of Beneficiary section of this form, if any named beneficiary predeceases me, the life proceeds shall be payable equally to the remaining named beneficiary or beneficiaries. If no named beneficiary survives me, any sum becoming payable under said Group Policy(ies) by reason of my death shall be payable as prescribed in said Group Policy(ies).
- If this Designation of Beneficiary provides for payment to a trustee under a trust agreement, Aetna Life Insurance Company shall not be obliged to inquire into the terms of the trust agreement and shall not be chargeable with knowledge of the terms thereof. Payment to and receipt by the trustee shall fully discharge all liability of said Insurance Company to the extent of such payment.
- If you live in one of the following community property states – Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin – your spouse may have a legal claim for a portion of the life insurance benefit under state law. If you name someone other than your spouse as beneficiary, payment of the death benefit may be delayed until your spouse's claim is resolved.

Instructions for Designation of Beneficiary

If these instructions do not answer all your questions, please contact your plan sponsor for assistance.

Please use only black ink to complete this form.

- If you make a mistake in completing this form, line out the erroneous information, add the correct information and initial the correction. **The printed material on this form should not be deleted or altered in any way.**
- **In all cases**, the relationship of the beneficiary, the beneficiary's Social Security Number, address and phone number should be included with the beneficiary designations.
- **Dollars and cents should not be specified**.
- If a minor child is named beneficiary, the child will not receive the benefits until age of majority.
- If a trustee is named beneficiary, show the exact name of the trust, date of the trust agreement, and the name and address of the trustee. **For example**, The John J. Smith Revocable Life Insurance Trust, dated January 1, 1994. John Smith, Trustee, 123 Apple Lane, Hartford, CT 06006.