New Jersey Application/Change Request
Aetna Life Insurance Company

A. Type of Activity - *Refer to instructions on back before completing this form. Print clearly.*

1. Enrollment

☐ New Enrollee/Subscriber

Requested Effective Date ___/___/___

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 Office ID Numbers and/or NPI Numbers: Primary/OB/Gyn

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

	Effective Date	Reason
☐ Remove Applicant*	/ /	
☐ Remove Spouse/Civil Union Partner*	/ /	
☐ Remove Domestic Partner*	/ /	
☐ Remove Dependent Child*	/ /	

* Please complete *Add/Change/Remove* and *Name* columns in Section D.

B. Applicant Information - Complete Sections B - H.

Last Name, First Name, M.I.			E-mail Address
Social Security Number	Home Number		Work Number
Home Address	Apt. No.	City, State	ZIP Code
Primary Residence	Apt. No.	City, State	ZIP Code

Are you a resident of the State of New Jersey? ☐ Yes ☐ No

Do you maintain a residence in any other state? ☐ Yes ☐ No If "Yes" name of state ______. How much time to you spend there each year? ______

C. Plan Option - Check one.

☐ Plan A/50 Deductible: ☐ $1,000 ☐ $2,500	☐ Plan C Indemnity: ☐ $1,000 ☐ $2,500	☐ Plan E NJ – HCTC*
☐ Plan B Indemnity: ☐ $1,000 ☐ $2,500	☐ Plan D Indemnity: ☐ $1,000 ☐ $2,500	☐ Plan F Indemnity: Basic and Essential

*HCTC is only available to those who qualify under the Trade assistance Act.

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. Attach proof of disability.

	(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex M F	Date of Birth (MM / DD / YYYY)	Social Security Number	Primary Office ID Number / NPI Number	Current Patient	Previous Coverage (check if Yes)
Applicant			☐ ☐	/ /		Office / NPI	Yes ☐	Yes ☐
Spouse/ Civil Union Partner			☐ ☐	/ /		Office / NPI	☐	☐
Domestic Partner			☐ ☐	/ /		Office / NPI	☐	☐
Child			☐ ☐	/ /		Office / NPI	☐	☐
Child			☐ ☐	/ /		Office / NPI	☐	☐
Child			☐ ☐	/ /		Office / NPI	☐	☐

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 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 or Pain
- ☐ 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
- ☐ l. Mental or Nervous Disorder
- ☐ m. Paralysis, Stroke or Epilepsy
- ☐ n. Does pregnancy exist? Expected Due Date __________

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 medication?

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. Previous Insurance - If "Yes" to previous coverage provide the following.

Name	Individual or Group Other (specify)	Plan Type Indemnity/ PPO/POS/HMO	Deductible Coinsurance Copay	Effective Date	Termination Date	Carrier Name	Policy Number

G. Dependent Information

Does any dependent listed in Section D live at a different address than the Applicant?

☐ Yes ☐ No If "Yes," identify the individual(s) and at what address

Explain the circumstances.

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

H. Availability of Coverage

Are you or any person named on this application eligible for coverage under a group or governmental plan, a church plan, Medicare, Medicaid, or any successor program?

☐ Yes ☐ No If "Yes," identify the individual(s), give name of carrier, policy number, and identify coverage type.

Are you or any person named on this application covered under a group or governmental plan, a church plan or Medicare?

☐ Yes ☐ No If "Yes," identify the individual(s), give name of carrier, policy number, and identify coverage type.

Was previous coverage, if any, terminated because a person covered under the plan committed fraud or for failure to pay premiums?

☐ Yes ☐ No If "Yes," identify the individual(s), and briefly describe the circumstances.

Were any of the individuals to be covered under an individual plan given the opportunity to continue previous coverage, if any, under COBRA or a similar state continuation law?

☐ Yes ☐ No If "Yes," did the individual(s) remain covered for the entire period that continuation was available to him or her?

☐ Yes ☐ No If "Yes," identify any person who did not continue for entire period available.

Were any of the individuals to be covered under an individual to be covered under an individual plan, as of the date of this application, continuously covered under a previous plan or plans for a period of 18 or more months without a break in coverage of 63 or more days?

☐ Yes ☐ No If "Yes" identify the individual(s).

Were any of the individuals' most recent prior creditable coverage under a group health plan, governmental plan, church plan, or health insurance coverage offered in connection with any such plan?

☐ Yes ☐ No If "Yes," identify individual(s) and include a Certificate of Creditable Coverage, if available.

I. Race/Ethnicity – *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

J. Payment Information

Payment Schedule	Payment Instrument	
☐ Monthly	☐ Check	☐ Credit Card Type/Name on Card ______
☐ Quarterly	☐ Money Order	No. ______ Exp. Date ______
☐ Yearly	☐ Automatic Bank Check *(attach voided check)*	Name on Card ______

K. Applicant Signature

If you have questions concerning the benefits and services provided by or excluded under this Policy, contact a Member Services. representative at 1-800-435-8742 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 applicant copy of this enrollment/change request.

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

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

L. Broker/General Agent Information

Signature of Preparer	Date	NJ Producer License Number
	/ /	
General Agent	Agent ID Number	

Eligibility Requirements

A. Eligibility requirements are set forth under the Individual Health Coverage Reform Act of 1992, P.L. 1992, c. 161 (N.J.S.A. 17B:27A-2 et seq.).

B. You MUST be a New Jersey resident.

C. EXCEPT as F. below applies, you and family members you wish to cover MUST NOT be eligible to be covered under a: group health plan; a group health benefits plan; a governmental plan (not including Medicaid); a church plan; or Medicare.

D. You and any family members you wish to cover are NOT eligible for a standard individual health benefits plan if covered by another individual health benefits plan UNLESS you are replacing the other individual health benefits plan by the one for which you are submitting this application.

E. If you do not specify an effective date in the application, your effective date shall be no later than the first day of the month following the month in which the completed application was dated and we receive premium payment directly or through our duly authorized agent UNLESS you submit your application during the November Open Enrollment Period (see F. below).

F. You may apply for coverage for yourself and family members who are covered under a group health plan, group health benefits plan, a governmental plan, a church plan, or Medicare during the November Open Enrollment Period IF you wish to replace the current coverage with a more comprehensive individual health benefits plan. The effective date of coverage under the individual health benefits plan in this instance will be January 1 of the calendar year following the November Open Enrollment Period. You SHOULD NOT terminate current coverage until the new coverage is effective.

Instructions

Section A - Type of Activity:
Provide **all** information that applies to the reason you are completing this application/change form.

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

Section C - Plan Option:
Check one Plan Option box, indicate Plan Option Name (where applicable), and check one Copay and/or Individual Deductible Amount (if applicable).

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 dependent, 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 a 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, OB/Gyn (if applicable). Indicate office ID number selection(s) on the form.
- If you are a current patient, please check the "Current Patient" box.
- You may obtain each provider's NPI number from the provider directory or at URL or/and by contacting the provider directory. 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.

Section E - Pre-Existing Conditions Statement:
Complete this section for **all** new enrollments.

Section F - Previous Insurance:
Complete this section for **all** new enrollments or coverage changes. Coverage includes individual or group coverage, governmental coverage, a church plan, or Medicare or Medicaid (including NJ FamilyCare).

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

Section K - Applicant Signature:

- Complete this section for **all** new enrollments, coverage changes, and terminations.
- Applicant **must** sign and date the Application/Change Request Form in order for it to be processed.

Conditions of Enrollment

Applicant Acknowledgment 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 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 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 this 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 Life Insurance Company individual policy coverage is provided by 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 Life Insurance Company
4. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the contract.

Misrepresentation

5. Any person who includes any false or misleading information on an Application/Change Request Form for a health benefits plan is subject to criminal and civil penalties.