



New Jersey Small Group Enrollment/Change Request

Aetna Health Inc. / Aetna Life Insurance Company

Aetna HMO, HNOnly, HNOption and POS plans are underwritten by Aetna Health Inc. Aetna Indemnity, EPO, 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 3 before completing this form. Please print clearly.

1. Enrollment <input type="checkbox"/> New Enrollee/Subscriber Effective Date ____ / ____ / ____ Date of Hire ____ / ____ / ____	2. Change – Check all that apply. <table border="0"> <tr> <td><input type="checkbox"/> Add Spouse/Civil Union Partner</td> <td>Date of Event</td> <td>Reason</td> </tr> <tr> <td><input type="checkbox"/> Add Domestic Partner</td> <td>____ / ____ / ____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Add Dependent Child</td> <td>____ / ____ / ____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Name Change</td> <td>____ / ____ / ____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Change Plan</td> <td>____ / ____ / ____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Other</td> <td>____ / ____ / ____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Add/Change Primary Office ID Number</td> <td>____ / ____ / ____</td> <td>_____</td> </tr> </table>	<input type="checkbox"/> Add Spouse/Civil Union Partner	Date of Event	Reason	<input type="checkbox"/> Add Domestic Partner	____ / ____ / ____	_____	<input type="checkbox"/> Add Dependent Child	____ / ____ / ____	_____	<input type="checkbox"/> Name Change	____ / ____ / ____	_____	<input type="checkbox"/> Change Plan	____ / ____ / ____	_____	<input type="checkbox"/> Other	____ / ____ / ____	_____	<input type="checkbox"/> Add/Change Primary Office ID Number	____ / ____ / ____	_____
<input type="checkbox"/> Add Spouse/Civil Union Partner	Date of Event	Reason																				
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3. Remove or Terminate – Check all that apply. <table border="0"> <tr> <td></td> <td>Effective Date</td> <td>Reason</td> </tr> <tr> <td><input type="checkbox"/> Remove Spouse/Civil Union Partner*</td> <td>____ / ____ / ____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Remove Domestic Partner*</td> <td>____ / ____ / ____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Remove Dependent Child*</td> <td>____ / ____ / ____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Employee Withdrawal/Termination</td> <td>____ / ____ / ____</td> <td>_____</td> </tr> </table> <p>NOTE: Employee must be enrolled for spouse/civil union partner/dependent(s) to have coverage.</p> <p>* Please complete Add/Change/Remove and Name columns in Section D.</p>		Effective Date	Reason	<input type="checkbox"/> Remove Spouse/Civil Union Partner*	____ / ____ / ____	_____	<input type="checkbox"/> Remove Domestic Partner*	____ / ____ / ____	_____	<input type="checkbox"/> Remove Dependent Child*	____ / ____ / ____	_____	<input type="checkbox"/> Employee Withdrawal/Termination	____ / ____ / ____	_____	4. Continuation of Coverage, i.e., COBRA, State, Total Disability - Not all options are available or applicable. Contact Employer for available options. Coverage for: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse/Civil Union Partner* <input type="checkbox"/> Dependent(s) Length of Continuation: <input type="checkbox"/> 18 mos. <input type="checkbox"/> 29 mos. <input type="checkbox"/> 36 mos. <input type="checkbox"/> Total Disability** Date of Loss of Coverage: ____ / ____ / ____ Date of Qualifying Event: ____ / ____ / ____ *Civil union partners are eligible to make an election pursuant to NJSGC, if applicable. **Attach proof of total disability.						
	Effective Date	Reason																				
<input type="checkbox"/> Remove Spouse/Civil Union Partner*	____ / ____ / ____	_____																				
<input type="checkbox"/> Remove Domestic Partner*	____ / ____ / ____	_____																				
<input type="checkbox"/> Remove Dependent Child*	____ / ____ / ____	_____																				
<input type="checkbox"/> Employee Withdrawal/Termination	____ / ____ / ____	_____																				

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.

<input type="checkbox"/> NJ HMO: Plan Option: _____ Rx Option: _____	<input type="checkbox"/> NJ HNOption: Plan Option: _____
<input type="checkbox"/> NJ HMO HSA Compatible: Plan Option: _____	<input type="checkbox"/> NJ HNOption HSA Compatible: Plan Option: _____ Rx Option: _____
Plan Administration: <input type="checkbox"/> Cal Yr <input type="checkbox"/> Plan Yr	Plan Administration: <input type="checkbox"/> Cal Yr <input type="checkbox"/> Plan Yr
<input type="checkbox"/> NJ Savings Plus HMO: Plan Option: _____	<input type="checkbox"/> NJ OA EPO: Plan Option: _____
<input type="checkbox"/> NJ Savings Plus HMO HSA Compatible: Plan Option: _____	<input type="checkbox"/> NJ OA EPO HSA Compatible: Plan Option: _____
Plan Administration: <input type="checkbox"/> Cal Yr <input type="checkbox"/> Plan Yr	Plan Administration: <input type="checkbox"/> Cal Yr <input type="checkbox"/> Plan Yr
<input type="checkbox"/> NJ HNOnly: Plan Option: _____ Rx Option: _____	<input type="checkbox"/> NJ MC: Plan Option: _____
<input type="checkbox"/> NJ HNOnly HSA Compatible: Plan Option: _____ Rx Option: _____	<input type="checkbox"/> NJ OA MC: Plan Option: _____
Plan Administration: <input type="checkbox"/> Cal Yr <input type="checkbox"/> Plan Yr	<input type="checkbox"/> NJ OA MC HSA Compatible: Plan Option: _____
<input type="checkbox"/> NJ Savings Plus HNOnly: Plan Option: _____	Plan Administration: <input type="checkbox"/> Cal Yr <input type="checkbox"/> Plan Yr
<input type="checkbox"/> NJ Savings Plus HNOnly HSA Compatible: Plan Option: _____	<input type="checkbox"/> NJ Indemnity: Plan Option: _____
Plan Administration: <input type="checkbox"/> Cal Yr <input type="checkbox"/> Plan Yr	<input type="checkbox"/> Other Plan: _____
<input type="checkbox"/> NJ QPOS: Plan Option: _____	

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. Attach proof of disability.

	(A) Add (C) Change (R) Remove	Last Name, First Name, M.I.	Sex		Birthdate			Social Security Number	Other Rx Drug Coverage	Other Health Coverage	Previous Coverage Check if "Yes"	Primary Office		Current Patient
			M	F	MM	DD	YYYY					ID Number	NPI Number	
Employee			<input type="checkbox"/>	<input type="checkbox"/>	__	/	__	__	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Office	Yes	
			<input type="checkbox"/>	<input type="checkbox"/>	__	/	__		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NPI	<input type="checkbox"/>	
Spouse/ Civil Union Partner			<input type="checkbox"/>	<input type="checkbox"/>	__	/	__		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Office	Yes	
			<input type="checkbox"/>	<input type="checkbox"/>	__	/	__		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NPI	<input type="checkbox"/>	
Domestic Partner			<input type="checkbox"/>	<input type="checkbox"/>	__	/	__		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Office	Yes	
			<input type="checkbox"/>	<input type="checkbox"/>	__	/	__		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NPI	<input type="checkbox"/>	
Child*			<input type="checkbox"/>	<input type="checkbox"/>	__	/	__		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Office	Yes	
			<input type="checkbox"/>	<input type="checkbox"/>	__	/	__		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NPI	<input type="checkbox"/>	
Child*			<input type="checkbox"/>	<input type="checkbox"/>	__	/	__		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Office	Yes	
			<input type="checkbox"/>	<input type="checkbox"/>	__	/	__		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NPI	<input type="checkbox"/>	
Child*			<input type="checkbox"/>	<input type="checkbox"/>	__	/	__		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Office	Yes	
			<input type="checkbox"/>	<input type="checkbox"/>	__	/	__		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NPI	<input type="checkbox"/>	

E. Other/Previous Coverage

Is your Spouse/Civil Union Partner/Domestic Partner Employed? Yes No If "Yes," give name & address of spouse/civil union partner's/domestic partner'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.

F. 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.

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

If you have questions concerning the benefits and services provided by or excluded under this Agreement, contact a Member Services representative at 1-866-529-2517 (for HMO, HNOonly and HNOOption products) or 1-888-802-3862 (for Traditional or PPO Products) before or after signing this form.

Employee Signature

I represent that all 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 X	Employee E-mail Address	Date
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Employer Verification (To Be Completed by Employer)

Employer Signature - Required X	Title	Date
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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 J – Employer Verification** on Page 3 of this 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 – I.

Section B – Employee Information:

- Complete all information in order for your application to be processed.

Section C – Medical Plan Options:

- 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:

- Do not complete this form for dependents over age 26, 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 names(s) of your dependents, if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
- If dependent is disabled and being continued beyond age 26, attach proof of disability.
- If you or your dependent(s) have other Health or Rx drug coverage, check the “Yes” box(es) and complete Section F – Other/Previous Coverage.
- If a dependent is Handicapped & financially dependent, check “Yes” & provide proof of handicapped status from the attending physician.
- From the appropriate 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.

Section E – Other/Previous Coverage:

Complete this section for all new enrollments or coverage changes. Coverage includes group coverage, HMO coverage, governmental coverage, a church plan or Medicare.

Section F – Dependent Information:

Complete this section for all new enrollments or coverage changes.

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.

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 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.

Misrepresentation

6. 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.