



New Jersey Enrollment/Change Request

Aetna Health Inc.

Employer Group Information - To Be Completed by Employer

| | | |
|------------|--------------|------------|
| Group Name | Group Number | Class Code |
|------------|--------------|------------|

A. Type of Activity - To Be Completed by Employer *Refer to instructions on back before completing this form. Print clearly.*

| | | | |
|--|---|--|---|
| 1. Enrollment <input type="checkbox"/> New Enrollee/Subscriber Effective Date _____ / / Date of Hire _____ / / | 2. Change - Check all that apply. <input type="checkbox"/> Add Spouse <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 Office ID Number Date of Event _____ / / _____ / / _____ / / _____ / / | 3. Remove or Terminate - Check all that apply. <input type="checkbox"/> Remove Spouse* <input type="checkbox"/> Remove Dependent Child* <input type="checkbox"/> Employee Withdrawal/Termination Effective Date _____ / / _____ / / _____ / / NOTE: Employee must be enrolled for spouse/dependent(s) to have coverage. * Please complete <i>Add/Change/Remove</i> and <i>Name</i> columns in Section D. | 4. Continuation of Coverage, i.e., COBRA, State - Not all options are available. Contact Employer for available options. Coverage For: <input type="checkbox"/> Employee <input type="checkbox"/> Dependents Length of Continuation: <input type="checkbox"/> 12 mos <input type="checkbox"/> 18 mos <input type="checkbox"/> 29 mos <input type="checkbox"/> 36 mos Date of Loss of Coverage: _____ / / Date of Qualifying Event: _____ / / |
|--|---|--|---|

B. Employee Information - Complete Sections B - G.

| | | | |
|------------------------|-----------------------------|-------------|-----------------------|
| Social Security Number | Last Name, First Name, M.I. | | Home Telephone () |
| Home Address | Apt. No. | City, State | ZIP Code |
| Employer Name | | | Work Telephone () |
| Work Address | City, State | | ZIP Code |

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

| | |
|---|---|
| Check One: <input type="checkbox"/> HMO <input type="checkbox"/> QPOS® <input type="checkbox"/> USAccess® <input type="checkbox"/> Aetna Open Access™ HMO <input type="checkbox"/> Aetna Choice™ POS | Indicate Plan Name Primary Copay: <input type="checkbox"/> \$5 <input type="checkbox"/> \$10 <input type="checkbox"/> \$15 <input type="checkbox"/> Other \$ _____ |
|---|---|

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. Attach proof if full-time college student.

| | (A)dd (C)hange (R)emove | Last Name, First Name, M.I. | Sex | | Birthdate | | | Social Security Number | Other Health Coverage | Other Rx Drug Coverage | Primary Office ID Number | Current Patient |
|----------|-------------------------------|-----------------------------|--------------------------|--------------------------|-----------|----|------|---------------------------------|---------------------------------|------------------------|---------------------------------|-----------------|
| | | | M | F | MM | DD | YYYY | | | | | |
| Employee | | | <input type="checkbox"/> | <input type="checkbox"/> | / | / | | Yes <input type="checkbox"/> | Yes <input type="checkbox"/> | | Yes <input type="checkbox"/> | |
| Spouse | | | <input type="checkbox"/> | <input type="checkbox"/> | / | / | | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | |
| Child | | | <input type="checkbox"/> | <input type="checkbox"/> | / | / | | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | |
| Child | | | <input type="checkbox"/> | <input type="checkbox"/> | / | / | | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | |
| Child | | | <input type="checkbox"/> | <input type="checkbox"/> | / | / | | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | |

E. Other 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 name & policy number of insurance carrier, HMO, or other source.

If "Yes" to Other Rx Drug Coverage (Section D), give name & policy number of insurance carrier, HMO, or other source.

F. Dependent Information

Does any dependent listed in Section D live at a different address than the Employee? Yes No
 If "Yes," who and what address?

Explain the circumstances.

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

G. Employee Signature

If you have questions concerning the benefits and services provided by or excluded under this Agreement, contact a Member Services representative at 1-800-323-9930 before 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 application. | Employee Signature - Required X | |
| | Date _____ / / | E-Mail Address _____ |

H. Employer Verification - To Be Completed by Employer

| | |
|---|-------------------|
| Employer Signature - Required X | |
| Title _____ | Date _____ / / |

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 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 box(es) indicating reason(s) for submitting application.
- Complete **Section H - 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 application in order for it to be processed.

Employee - Complete Sections B - G.

Section B - Employee 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* Primary 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 dependent(s), if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
- If a dependent is a full-time college student, you **must** attach a current course schedule or a letter from the school confirming full-time student status (12 or more credits).
- If you or your dependent(s) have other Health or Rx drug coverage, check off the "Yes" box(es) and complete Section E - Other Insurance.
- From the appropriate provider directory, locate the **6-digit** office ID number for the primary care physician. Indicate office ID number selection on the form.
- If you are a current patient, please check the "Current Patient" box.

Section E - Other Insurance:

Complete this section for all new enrollments or coverage changes.

Section F - Dependent Information:

Complete this section for all new enrollments or coverage changes.

Section G - Employee Signature:

- Complete this section for all new enrollments, coverage changes and terminations.
- Employee must sign and date the application in order for it to be processed.

Section H - Employer Verification:

- Employer must complete this section for all new enrollments, coverage changes and terminations.
- Employer must sign and date the application 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., 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. 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 Health Inc. plan, coverage is provided by Aetna Health Inc. 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.
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 application or enrollment form for a health benefits plan is subject to criminal and civil penalties.