New Jersey Enrollment/Change Request
Aetna Life Insurance Company

Employer Group Information - To Be Completed by Employer

Group Name	Group Number	Suffix	Account	Plan

A. Type of Activity - To Be Completed by Employer To Add, Change or Remove coverage for dependents over the limiting age, but less than 30, Aetna form HINT Supplemental Enrollment Information Form, Implementing P.L. 2005, c. 375, must be completed. *Refer to instructions on back before completing this form. 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 and/or NPI 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 *Add/Change/Remove* and *Name* columns in Section D.

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* ☐ Dependents

Length of Continuation: ☐ 12 mos ☐ 18 mos ☐ 29 mos ☐ 36 mos ☐ Total Disability - Attach proof of total disability

Date of Loss of Coverage: / /

Date of Qualifying Event: / /

* Civil Union Partners are ineligible to make an election for COBRA continuation.

B. Employee Information - Complete Sections B - G.

Last Name, First Name, M.I.		Social Security Number	Home Telephone ( )	
Home Address	Apt. No.	City, State		ZIP Code
Employer Name	Email Address	Work Telephone ( )	Date of Employment:	Hours Worked Per Week:
Work Address		City, State		ZIP Code

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

Check One:

- ☐ Elect Choice℠ EPO
- ☐ Manage Choice℠ POS
- ☐ Aetna Choice™ POS II
- ☐ Aetna HealthFund™
- ☐ Aetna Open Access™ Elect Choice
- ☐ Aetna Open Access™ Managed Choice
- ☐ Open Choice℠ PPO
- ☐ Traditional Choice℠
- ☐ Aexcel℠
- ☐ Aexcel℠ Plus
- ☐ HMO (IMO Use Only)
- ☐ 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 post secondary student.

Relationship Code	(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex M F	Birthdate MM DD YYYY	Social Security Number	Other Health Coverage Yes	Other Rx Drug Coverage Yes	Primary Office ID Number	NPI Number	Current Patient Yes	Previous Coverage Check if yes
Employee			☐ ☐	/ /		☐	☐			☐	☐
			☐ ☐	/ /		☐	☐			☐	☐
			☐ ☐	/ /		☐	☐			☐	☐
			☐ ☐	/ /		☐	☐			☐	☐
			☐ ☐	/ /		☐	☐			☐	☐
			☐ ☐	/ /		☐	☐			☐	☐

E. Other/Previous Insurance

Is your Spouse/Civil Union Partner employed? ☐ Yes ☐ No If "Yes," give name & address of your spouse/civil union 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 what address?

Explain the circumstances.

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

*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 or after signing this form.*

G. Employee Signature

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 this Enrollment/Change Request. I authorize deductions from my earnings for any required contributions.

Employee Signature - *Required* X

Date / / E-Mail Address

H. Employer Verification - To Be Completed by Employer

Employer Signature - *Required* X

Title Date / /