aetna®

New Jersey Employee Enrollment/Change Request

For Employer Groups with 101 or More Employees

Aetna Life Insurance Company

Aetna plans are underwritten by Aetna Life Insurance Company.

Waiving Insurance/Change Insurance

Member Aetna ID Number (if available)

Employer Name	INSTRUCTIONS: You, the employee, must complete this enrollment form in full or it will be returned to you resulting in a delay in processing. You are solely responsible for its accuracy and completeness. **If waiving coverage, please complete Sections C and F.**
Hammonton Board of Ed.	

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 4 before completing this form. Please Print clearly.***

1. Enrollment

- ☐ New Hire
- ☐ Rehire/Reinstatement
- ☐ New Group Enrollment
- ☐ Late Enrollment
- ☐ Other Open Enrollment

Effective Date: 8 / 1 / 2017

Date of Hire: / /

2. Change – *Check all that apply.*

	Date of Event	Reason
☐ Change of Coverage	/ /	
☐ Add Spouse/Civil Union/ Domestic Partner/Dependent Child	/ /	
☐ Name Change	/ /	
☐ Other	/ /	
☐ Add/Change Primary Office ID Number or NPI Number	/ /	

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

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

	Effective Date	Reason
☐ Employee Termination	/ /	
☐ Remove Spouse/Civil Union/ Domestic Partner/ Dependent Child*	/ /	
☐ Cancel Coverage	/ /	

NOTE: Employee must be enrolled for spouse/civil union/domestic 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.

☐ COBRA ☐ State Continuation ☐ Total Disability

Coverage for:

☐ Employee ☐ Spouse/Civil Union/Domestic Partner* ☐ Dependent(s)

Length of Continuation: ☐ 18 mos. ☐ 29 mos. ☐ 36 mos.

☐ Total Disability – Attach proof of total disability

Date of Loss of Coverage: / /

Date of Qualifying Event: / /

Reason: _____

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

B. Medical Plan Options – Your selection must be offered by your employer.

Control/Group No.	Suffix	Account	Plan No.	Class Code

Check One.

- ☐ Managed Choice® POS – Plan Option: _____
- ☐ Aetna Choice® POS II – Plan Option: _____
- ☐ Aetna HealthFund™ – Plan Option: _____
- ☐ Aetna Open Access® Managed Choice – Plan Option: Aetna 15
- ☐ Open Choice® PPO – Plan Option: _____
- ☐ Traditional Choice® – Plan Option: _____
- ☐ Other – Plan Option: _____

C. Employee Information - ***Must be completed by the employee.***

Social Security Number	Last Name, First Name, M.I.		Home Telephone	Primary Language Spoken (Optional)
Home Address		**Apt. No.**	**City, State**	**ZIP Code**
Work Address		**City, State**	**ZIP Code**	**Work Telephone**
No. of Hours Worked Per Week	**Check One:** ☐ Full-Time ☐ Part-Time ☐ 1099 ☐ Retired ☐ Seasonal ☐ Temporary ☐ COBRA ☐ Union		**Marital Status** ☐ Married ☐ Single ☐ Civil Union Partner ☐ Domestic Partner	**No. of Dependents Including Spouse/Civil Union/ Domestic Partner**

D. Individuals Covered - *List individuals for whom you are enrolling or adding/changing/removing coverage. Attach additional sheets if necessary.*

NOTE: While the Federal Patient Protection and Affordable Care Act mandates coverage of dependent children up to age 26, your plan may allow coverage beyond age 26. Some exceptions apply. Please refer to your plan documents or contact your benefits administrator.

(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex M/F	Social Security Number	Birthdate MM DD YYYY	Disabled	Other Health Coverage	Other Rx Drug Coverage	Primary Office ID Number (if applicable) / NPI Number	Current Patient
	1. Employee				Yes N/A	Yes ☐	Yes ☐	Office / NPI	Yes ☐
	2. Spouse/Civil Union/Domestic Partner				N/A	☐	☐	Office / NPI	☐
	3. Child				☐	☐	☐	Office / NPI	☐
	4. Child				☐	☐	☐	Office / NPI	☐

E. Race/Ethnicity – Optional (This information is designed for the purpose of data collection and will not be used for determining eligibility, rating or claim payment.)

Employee 1. ☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____

Spouse/Civil Union/Domestic Partner 2. ☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____

Child 3. ☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____

Child 4. ☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____

F. Declination/Waiver of Coverage - *To be completed if medical and/or dental coverage is declined or refused by an eligible employee and/or their eligible family members.*

Coverage Declined for: ☐ Myself ☐ Dependents ☐ Spouse/Civil Union/Domestic Partner

Reason for Declining Coverage *(If applicable, please attach front/back of your health coverage ID card.)*:

☐ Covered by Spouse/Civil Union/Domestic Partner's group coverage - Carrier Name and ID Number

_____

☐ Enrolled in other Insurance Plans – Insurance Company Name and ID:

_____

☐ Medicare ☐ Covered by TRICARE or CHAMPVA ☐ Other (Explain): _____

☐ Spouse/Civil Union/Domestic Partner covered by employer's group medical coverage

I was given the opportunity to enroll in the medical plan offered by my employer and underwritten by Aetna Life Insurance Company; however, I refuse the above coverage(s). By declining this group coverage I acknowledge that I and/or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage.

Please sign here ONLY if you are declining coverage for yourself or your dependent(s).

X Employee Signature _____ ***Date (Month/Day/Year)*** _____

G. Dependent Information

Does any dependent listed in Section **D** live at another address? ☐ Yes ☐ No
If **Yes**, who and what address?

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

H. Other Insurance

If you have checked **Yes** to Other **Health** or Rx Drug Coverage (Section C), provide name and policy number of insurance carrier, HMO, or other source, a copy of the insurance card, and start date of the coverage.

Is your Spouse/Civil Union/Domestic Partner employed? ☐ Yes ☐ No If **Yes**, provide name and address of Spouse's/Civil Union/Domestic Partner's employer.

Name of Covered Individual	Carrier Name	Group Number	Start Date	Termination Date	Health
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

If you have questions concerning the benefits and services provided by or excluded under this Plan, contact a Member Services representative at 1-800-323-9930 before or after signing this form.