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.

Open Enrollment

Member Aetna ID Number (if available)

Employer Name
Camden City School District

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.**

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 01 / 01 / 2019

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: **Circle one: $10 $15 $15/25 $20/30 $20/35**
- ☐ Open Choice® PPO – Plan Option: ______
- ☐ Traditional Choice® – Plan Option: ______
- ☐ Other – Plan Option: **HMO PLAN Circle copay: $10 $15/25 $20/30 $20/35**

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.

I. Conditions of Enrollment

Applicant Acknowledgments and Agreements

On behalf of myself and the dependents listed in Section D, 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. **Please note that a consumer report includes information regarding the enrollee's character, general reputation, personal characteristics, and mode of living. If you would like a copy of your consumer report obtained by Aetna, you may contact Member Services. Aetna will provide a copy of the report upon request.**

   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 the 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 plan, 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 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 Enrollment/Change Request Form for a health benefits plan is subject to criminal and civil penalties.

J. Employee Signature

I represent that all the information supplied in this application is true and complete to the best of my knowledge and belief. I hereby agree to the conditions of enrollment contained in this Enrollment/Change Request form. I authorize deductions from my earnings for any required contributions.

Employee Signature - Required	*Employee E-mail Address (optional)*	*Date (Month/Day/Year)*
X		

K. Employer Verification – To be completed by Employer

Employer Signature – Required	*Title*	*Date (Month/Day/Year)*
X		

Employee copy may be used as 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.

Please make a copy for your records. **Visit us at www.aetna.com.**