



New Jersey Small Group Enrollment/Change Request

Aetna Health Inc. / Aetna Life Insurance Company

Aetna HMO, HNOnly, HNOption and QPOS plans are underwritten by Aetna Health Inc. Aetna Indemnity, OA EPO, OA MC 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 4 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="1"> <thead> <tr> <th></th> <th>Date of Event</th> <th>Reason</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Add Spouse/Civil Union Partner</td> <td>____/____/____</td> <td>_____</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> </tbody> </table>		Date of Event	Reason	<input type="checkbox"/> Add Spouse/Civil Union Partner	____/____/____	_____	<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	____/____/____	_____
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<input type="checkbox"/> Add Spouse/Civil Union Partner	____/____/____	_____																							
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3. Remove or Terminate – Check all that apply. <table border="1"> <thead> <tr> <th></th> <th>Effective Date</th> <th>Reason</th> </tr> </thead> <tbody> <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> </tbody> </table> <p>NOTE: Employee must be enrolled for spouse/civil union partner/dependent(s) to have coverage. * Please complete Section D for each member being removed or terminated.</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: ____/____/____ Qualifying Event #: _____*** * Civil union partners are eligible to make an election pursuant to NJSGC, if applicable. ** Attach proof of disability. *** Refer to list of qualifying event numbers on Page 4-Instructions section.									
	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/continuing coverage. Attach sheet to list additional children. Attach proof of disability.

1	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continuation <input type="checkbox"/> Other				
	Employee Name (Last, First, M.I.) ----- <i>If a name change, indicate prior name:</i>			Sex (M/F) 	Birthdate (MM/DD/YYYY) / /
Primary Office ID Number		NPI Number	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary Care Provider Name	
Primary Office Address/Location				ZIP Code +4	
Other Health Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Payer Name: _____ Policy Number: _____ Medicare ID Number, if any: _____			Other Rx Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Payer Name: _____ Policy Number: _____ Medicare ID Number, if any: _____		
2	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Other <input type="checkbox"/> Continue Spouse <input type="checkbox"/> Continue Civil Union Partner (NJSGC)				
	Name (Last, First, M.I.) <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Civil Union Partner		Sex (M/F) 	Social Security Number 	Birthdate (MM/DD/YYYY) / /
Primary Office ID Number		NPI Number	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary Care Provider Name	
Primary Office Address/Location				ZIP Code +4	
Other Health Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Payer Name: _____ Policy Number: _____ Medicare ID Number, if any: _____			Other Rx Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Payer Name: _____ Policy Number: _____ Medicare ID Number, if any: _____		
3	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continuation <input type="checkbox"/> Other				
	Name (Last, First, M.I.) <input type="checkbox"/> Child		Sex (M/F) 	Social Security Number 	Birthdate (MM/DD/YYYY) / /
Primary Office ID Number		NPI Number	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary Care Provider Name	
Primary Office Address/Location				ZIP Code +4	
Other Health Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Payer Name: _____ Policy Number: _____ Medicare ID Number, if any: _____			Other Rx Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Payer Name: _____ Policy Number: _____ Medicare ID Number, if any: _____		
4	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continuation <input type="checkbox"/> Other				
	Name (Last, First, M.I.) <input type="checkbox"/> Child		Sex (M/F) 	Social Security Number 	Birthdate (MM/DD/YYYY) / /
Primary Office ID Number		NPI Number	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary Care Provider Name	
Primary Office Address/Location				ZIP Code +4	
Other Health Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Payer Name: _____ Policy Number: _____ Medicare ID Number, if any: _____			Other Rx Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Payer Name: _____ Policy Number: _____ Medicare ID Number, if any: _____		

continued on next page

D. Individuals Covered (Continued)

5	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continuation <input type="checkbox"/> Other				
	Name (Last, First, M.I.) <input type="checkbox"/> Child		Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /
Primary Office ID Number		NPI Number	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary Care Provider Name	
Primary Office Address/Location				ZIP Code +4	
Other Health Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Payer Name: _____ Policy Number: _____ Medicare ID Number, if any: _____			Other Rx Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Payer Name: _____ Policy Number: _____ Medicare ID Number, if any: _____		

6	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continuation <input type="checkbox"/> Other				
	Name (Last, First, M.I.) <input type="checkbox"/> Child		Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /
Primary Office ID Number		NPI Number	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary Care Provider Name	
Primary Office Address/Location				ZIP Code +4	
Other Health Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Payer Name: _____ Policy Number: _____ Medicare ID Number, if any: _____			Other Rx Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Payer Name: _____ Policy Number: _____ Medicare ID Number, if any: _____		

E. Additional Spouse/Civil Union Partner/Domestic Partner Information – If not applicable, please mark as “NA.”

Is your Spouse/Civil Union Partner/Domestic Partner employed? Yes No If “Yes,” give name, address and telephone number of spouse’s/civil union partner’s/ domestic partner’s employer.

F. Additional Child Information

List any child who lives at a different address from the employee. If multiple children live at the same address, you may list them together.

Name	Address	Reason

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

List any dependent child who is incapacitated and over age 26. Additional forms will need to be completed by you and your child’s doctor.

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

H. Employee Signature

I represent that all information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in 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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I. Employer Verification (To Be Completed by Employer) The requested activity is believed eligible and is approved by the Employer.

Employer Signature - Required X	Title	Date
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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.

Instructions

Employer: You must complete the Employer Group Information and Sections A and I in order for this application to be processed.

Employee: You must complete Sections B through H.

- Please PRINT except when a signature is requested.
- If a dependent is disabled and you want to continue his or her coverage beyond age 26, you do not have to make a COBRA/NJSGC or Dependent Under 31 election. Instead, select "Other" in Section A2, and attach proof of disability.
- For provider addresses, include the zip code plus the four digit extension.
- You can obtain each provider's correct name, address and 6-digit office ID number for the primary care physician from the appropriate directory. Indicate office ID number selection(s) on the form.
- You can obtain the 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.
- **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.**

Qualifying Events

COBRA and NJSGC

- C1. Termination of job or reduction in hours.
- C2. Employee enrollment in Medicare (COBRA only)
- C3. Divorce (COBRA/NJSGC); civil union dissolution (NJSGC)
- C4. Death of employee
- C5. Loss of dependent child status under the plan
- C6. Disability (occurring subsequent to another qualifying event)