New Jersey Business (51 - 100 Eligible Employees) Employee Enrollment/Change Form

Life, Accidental Death & Personal Loss, Disability, Aetna Vision, Aetna Managed Choice and Aetna Indemnity plans are underwritten by Aetna Life Insurance Company. The In-network component of our Savings Plus Health Network Option plans is underwritten by Aetna Health Inc. The Out-of-Network component of our Savings Plus Health Network Option plans is underwritten by Aetna Health Insurance Company. DMO and Voluntary DMO coverage is underwritten by Aetna Dental Inc. Aetna Life Insurance Company provides all other dental coverage. For Vision coverage, certain claims administration services are provided by First American Administrators, Inc. and certain network administration services are provided through EyeMed Vision Care, LLC ("EyeMed").

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 A and G.**

Member Aetna ID Number (if available)

Company Name			
Effective Date **Date of Hire** **BWP** ☐ Class 1 ☐ Class 2	☐ New Hire ☐ Rehire/Reinstatement* ☐ New Group Enrollment ☐ Waiver ☐ Open Enrollment *Does not apply to Supplemental or Dependent Life Insurance	☐ Add Spouse/Civil Union/Domestic Partner ☐ Add Dependent Child ☐ Change of Coverage ☐ Name Change	☐ Employee Termination Date: _____ ☐ Remove Spouse/Civil Union/Domestic Partner ☐ Remove Dependent Child ☐ Cancel Coverage ☐ Other _____
☐ **COBRA for:** ☐ Employee ☐ Dependent		Length of Continuation: ☐ 18 ☐ 36 ☐ Other _____	
Qualifying Event _____	Original Qualifying Event Date _____	Loss of Coverage Date _____	

A. Employee Information – *Must be completed by the employee.*

Social Security Number	Last Name, First Name, M.I.		Primary Language Spoken (optional)
Home Address	Apt. No.	City, State	ZIP Code
Work Address		City, State	ZIP Code
Home Telephone ( ) -	Work Telephone ( ) -	No. of Hours Worked Per Week	Number of Dependents (including Spouse/ Civil Union/Domestic Partner)
Salary ☐ Hourly **$** ☐ Weekly ☐ Monthly	Check One ☐ Full-Time ☐ 1099 ☐ Union ☐ Seasonal ☐ Part-Time ☐ Retiree ☐ COBRA ☐ Temporary		Check One ☐ Married ☐ Civil Union Partner ☐ Single ☐ Domestic Partner

B. Coverage Selection – *Please print clearly, using black ink. (Shaded sections for Employer/Aetna Use Only)*

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

1. Health Benefits

☐ NJ Savings Plus Health Network Option – Plan Option: _____

☐ NJ Managed Choice (MC) – Plan Option _____

☐ NJ Open Access® Managed Choice (OA MC) – Plan Option _____

☐ NJ Open Access® Managed Choice (OA MC) HSA Compatible – Plan Option _____

Plan Administration: ☐ Calendar Year ☐ Plan Year

☐ NJ Indemnity

continued on next page

B. Coverage Selection *(Continued)*

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

2. Dental Benefits

Contributory (non-voluntary) Plans: Option: _____ *FOC:* ☐ DMO® *or* ☐ PPO

Voluntary Plans: Option: _____ *FOC:* ☐ DMO® *or* ☐ PPO

Before today, were you covered under this employer's dental plan? ☐ Yes ☐ No

Creditable coverage is allowed for new members enrolling in voluntary takeover groups. New hires please see below if applicable:

New Hire selecting a Voluntary Plan **and your Aetna plan is a takeover group**: Were you covered for 12 months under a dental plan within the last 90 days that included both Preventive and Basic coverage? Discount dental and preventive only plans do not apply. ☐ Yes ☐ No

Control/Group No.	Suffix	Account	Plan No.

3. Life and Disability

Life Options – Check applicable boxes.

☐ **Employee**	☐ Basic Life/AD&PL Ultra	☐ Supplemental Life	☐ Supplemental AD&PL	
☐ **Spouse**	☐ Dependent Life	☐ Dependent Supplemental Life	☐ Dependent Supplemental AD&PL	
☐ **Child**	☐ Dependent Life	☐ Dependent Supplemental Life	☐ Dependent Supplemental AD&PL	

DESIGNATION OF BENEFICIARY – Carefully review Additional Conditions and Instructions for Designation of Beneficiary on Page 7.

Life Products require the employee to designate a beneficiary for benefits. A beneficiary is the person or entity who will receive the benefit payment. A primary beneficiary will be the first to receive the benefit. A contingent beneficiary will only receive the benefit payment if the primary beneficiary dies or is no longer available. The employee is automatically the primary beneficiary for dependent life and AD&PL benefits.

Beneficiary For:	**Full Name(s) or Entity (Trust or Estate)**	**Date of Birth**	**Social Security Number / Tax ID Number**	**Address** (Number, Street, Apt. No., City, State, ZIP Code)	**Phone**	**Relationship to Employee**	**% of Benefit** (must equal 100%)
Basic Life Primary							
Basic Life Contingent							
Supplemental Life Primary							
Supplemental Life Contingent							

SPOUSAL CONSENT FOR COMMUNITY PROPERTY STATES – See Additional Conditions and Instructions for Designation of Beneficiary Section on Page 7.

Please note that an Employee is under no obligation to complete the Spousal Consent section on this form.

I am aware that my spouse, the Employee named above, has designated someone other than me to be the beneficiary of group Life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.

Spouse Signature _____ **Date** _____

Disability Options - Check applicable boxes. **Employee only**

Short Term Disability ☐ Yes ☐ No

Long Term Disability ☐ Yes ☐ No

Control/Group No.	Suffix	Account	Plan No.

4. Vision

Aetna Vision Preferred ☐ Yes ☐ No *Check applicable box.*

C. Individuals Covered - *List individuals for whom you are enrolling or adding/changing/removing coverage. Attach additional sheets if necessary.* Disability coverage is not available for dependents. If coverage does not apply, please ✓ N/A in the appropriate box.
NOTE FOR MEDICAL COVERAGE: 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.

1	(**A**)dd (**C**)hange ___ (**R**)emove	**Employee Name** (Last, First, M.I.)			Sex (M/F)	Birthdate (MM/DD/YYYY) / /	
Coverage Election *(Check only Coverage(s) you are applying for)* ☐ Medical ☐ Dental ☐ Life ☐ Disability ☐ Vision		Primary Medical Office ID Number *(if applicable)* For Medical Only	Current Patient **Yes** ☐ **N/A** ☐	Dental Office ID Number *(if applicable)* For Dental Only		Current Patient **Yes** ☐ **N/A** ☐	

2	(**A**)dd (**C**)hange ___ (**R**)emove	**Name** (Last, First, M.I.) ☐ **Spouse** ☐ **Civil Union** ☐ **Domestic Partner**			Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /
Coverage Election *(Check only Coverage(s) you are applying for)* ☐ Medical ☐ Dental ☐ Life ☐ Vision		Primary Medical Office ID Number *(if applicable)* For Medical Only	Current Patient **Yes** ☐ **N/A** ☐	Dental Office ID Number *(if applicable)* For Dental Only		Current Patient **Yes** ☐ **N/A** ☐	

3	(**A**)dd (**C**)hange ___ (**R**)emove	**Child Name** (Last, First, M.I			Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /
Disabled **Yes** ☐ **N/A** ☐	Coverage Election *(Check only Coverage(s) you are applying for)* ☐ Medical ☐ Dental ☐ Life ☐ Vision	Primary Medical Office ID Number *(if applicable)* For Medical Only	Current Patient **Yes** ☐ **N/A** ☐	Dental Office ID Number *(if applicable)* For Dental Only		Current Patient **Yes** ☐ **N/A** ☐	

4	(**A**)dd (**C**)hange ___ (**R**)emove	**Child Name** (Last, First, M.I			Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /
Disabled **Yes** ☐ **N/A** ☐	Coverage Election *(Check only Coverage(s) you are applying for)* ☐ Medical ☐ Dental ☐ Life ☐ Vision	Primary Medical Office ID Number *(if applicable)* For Medical Only	Current Patient **Yes** ☐ **N/A** ☐	Dental Office ID Number *(if applicable)* For Dental Only		Current Patient **Yes** ☐ **N/A** ☐	

5	(**A**)dd (**C**)hange ___ (**R**)emove	**Child Name** (Last, First, M.I			Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /
Disabled **Yes** ☐ **N/A** ☐	Coverage Election *(Check only Coverage(s) you are applying for)* ☐ Medical ☐ Dental ☐ Life ☐ Vision	Primary Medical Office ID Number *(if applicable)* For Medical Only	Current Patient **Yes** ☐ **N/A** ☐	Dental Office ID Number *(if applicable)* For Dental Only		Current Patient **Yes** ☐ **N/A** ☐	

6	(**A**)dd (**C**)hange ___ (**R**)emove	**Child Name** (Last, First, M.I			Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /
Disabled **Yes** ☐ **N/A** ☐	Coverage Election *(Check only Coverage(s) you are applying for)* ☐ Medical ☐ Dental ☐ Life ☐ Vision	Primary Medical Office ID Number *(if applicable)* For Medical Only	Current Patient **Yes** ☐ **N/A** ☐	Dental Office ID Number *(if applicable)* For Dental Only		Current Patient **Yes** ☐ **N/A** ☐	

D. Health Questionnaire – Complete for:

- Employer groups with no group medical coverage;
- A newly formed business with no group medical coverage
- Employees with no prior group coverage.

NOTE: Individuals requesting life coverage above the Guaranteed Issue amount or a Life/Disability Late Enrollee (enrolling more than 31 days after eligible) must complete an Evidence of Insurability Form and send to the address located on the form.

Health History for Employees and your Dependents.

- ALL of the questions must be answered by you and your dependents or the enrollment form will be returned.
- Incomplete enrollment forms may delay the effective date of your coverage.

NOTE: Before submitting this completed form to your employer, you may wish to protect the confidentiality of your health information by taping or stapling the form so Pages 3 is not visible.

List all individuals enrolling for coverage. Name	Sex	Age	Height	Weight	Cigarette Smoker	Currently Taking Prescription Medication(s)
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No

E. Answer all questions.

1. Within the last **five** years has anyone applying for coverage consulted, received treatment, by a doctor, psychiatrist, psychologist, or other practitioner or been diagnosed with any of the following conditions or disorders? (Check all that apply.) ☐ Yes ☐ No

a. ☐ AIDS/ARC/HIV
b. ☐ Diabetes
c. ☐ Infertility
d. ☐ Endocrine/Metabolic
e. ☐ Pancreas
f. ☐ Liver/Hepatitis
g. ☐ Immune System
h. ☐ Blood Disorder
i. ☐ Hemophilia
j. ☐ Epilepsy/Seizure
k. ☐ Heart Disorder/ Disease
l. ☐ Paralysis/Paresis
m. ☐ Tumor/Cyst/Growth
n. ☐ Systemic or Discoid Lupus
o. ☐ Lung or Respiratory
p. ☐ Alcohol or Drug Use
q. ☐ Kidney/Bladder/Urinary
r. ☐ Circulatory/Vascular
s. ☐ Digestive/Stomach/Intestinal
t. ☐ Central Nervous System
u. ☐ Connective Tissue Disorder
v. ☐ Pituitary/Adrenal/Growth Disorder
w. ☐ Birth Defects/Congenital Abnormalities
x. ☐ Arthritis/Bone/Joint/Muscle/Prosthetic Device
y. ☐ Mental/Nervous/Emotional/Eating Disorder
z. ☐ Stroke/Brain/Neurological
aa. ☐ Transplant: ☐ Recommended ☐ Pending ☐ Complete
bb. ☐ Advised to have ☐ tests, ☐ surgery, ☐ hospitalization or is ☐ treatment needed, or ☐ course of treatment not yet determined
cc. ☐ Cancer: Type:_____ Stage _____ ☐ Surgery ☐ Chemo ☐ Radiation
dd. ☐ Using: ☐ Crutches ☐ Walker ☐ Wheelchair
ee. ☐ Other _____

2. Is any female currently pregnant? If so, provide due date _____ Check applicable boxes: ☐ C section planned ☐ Multiple Births expected (# _____) ☐ Complications: ☐ Past or ☐ Present ☐ Yes ☐ No
3. Has anyone applying for coverage incurred medical expenses in excess of $5,000 in the past 24 months? ☐ Yes ☐ No
4. Has anyone applying for coverage been prescribed medications in the past 12 months? ☐ Yes ☐ No
5. Does anyone applying for coverage have a known condition that requires on-going treatment? ☐ Yes ☐ No

F. Provide details below to any boxes checked above. *(If additional space is needed, attach a separate sheet and be sure to sign and date the sheet.)*

Ques. No.	Name of Individual	Condition/Diagnosis/ Treatment	Date of Onset	Date Treatment Ended	Names of Prescription Medication	Dosage	Still Taking Medication
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

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

☐ Employee:	☐ Medical ☐ Dental ☐ Disability	☐ Life ☐ Vision	
☐ Spouse/Civil Union/Domestic Partner:	☐ Medical ☐ Dental	☐ Life ☐ Vision	
☐ Child(ren):	☐ Medical ☐ Dental	☐ Life ☐ Vision	

Reason for declining coverage

- ☐ Spouse/Civil Union/Domestic Partner group coverage
- ☐ Parental group coverage
- ☐ Medicare
- ☐ Medicaid
- ☐ Retiree coverage
- ☐ Another group plan provided by my employer
- ☐ COBRA coverage
- ☐ Insurance through another job
- ☐ TRICARE or CHAMPVA
- ☐ Individual coverage – On Exchange
- ☐ Individual coverage – Off Exchange
- ☐ Do not want
- ☐ Other _____

I acknowledge I have been given the right to apply for this coverage; however, I am electing not to enroll. 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).	*Date (Month/Day/Year)*
Employee Signature X	

H. Dependent Information

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

I. Coordination of Benefits

Will you have other health insurance at the same time as this coverage? ☐ Yes ☐ No

Name of Person	Carrier Name	Name of Person	Carrier Name

If you have questions concerning the benefits and services provided by or excluded under this Plan, contact a Member Services representative at 1-877-350-2217 (for Health Network Option products) or 1-888-802-3862 (for Indemnity or MC products) before or after signing this form.

J. Conditions of Enrollment

Applicant Acknowledgments and Agreements

On behalf of myself and the dependents listed, I agree to or with the following:

1. a) I authorize the sources stated below to give to Aetna Health Inc. and/or Aetna Health Insurance Company and/or Aetna Life Insurance Company, and/or Aetna Dental 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. **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 Health Inc. and/or Aetna Health Insurance Company and/or Aetna Life Insurance Company and/or Aetna Dental 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 the authorization if I request one.
   d) I agree that a photocopy of this authorization is as valid as the original.

   This authorization is voluntary. However, I understand that if I refuse to sign this authorization form, my ability to enroll in the medical plans described above may be affected. I have the right to revoke this authorization in writing to Aetna at any time except to the extent that my information has already been used or disclosed in reliance on this authorization. However, because this information is essential to the administration of the plans, I understand that my revocation of this authorization may result in cancellation of my enrollment in the medical plans described above.
2. I acknowledge by enrolling in an Aetna plan, coverage is provided by Aetna Health Inc. and/or Aetna Health Insurance Company and/or Aetna Life Insurance Company and/or Aetna Dental 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. and/or Aetna Health Insurance Company and/or Aetna Life Insurance Company and/or Aetna Dental 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 Enrollment/Change Request Form for a Life or Health benefits plan is subject to criminal and civil penalties.

K. 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.

If you wish to receive documents electronically, please refer to Aetna Navigator® at http://www.aetna.com/individuals-families/aetna-navigator.html.

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

L. 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 Health Inc., Aetna Health Insurance Company, or Aetna Life Insurance Company prior to visiting a specialist or admission to a hospital.

Instructions

Employer

- Complete the **Employer Group Information** at the top of the form.
- Complete **Section L - Employer Verification**.
- Employer must complete this section for all new enrollments, coverage changes and terminations.
- Employer must sign and date the Enrollment/Change Request form in order for it to be processed.

Employee – Complete Sections A - K

Section A – Coverage Selection

- Check one plan option box for each coverage that is offered by your employer.
- **Medical -** Check one Plan Option box and indicate Plan Option name (where applicable).
- **Dental** – Enter Plan Option and FOC selection (if applicable).
- **Life/Disability** – Check applicable boxes. Complete all requested Beneficiary information.

Section B - Employee Information: Complete **all** information in order for your application to be processed.

Section C - Individuals Covered:

- Do not complete this form 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.
- 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 dependents, if applicable. Indicate Sex, Social Security Number and Birthdate for each individual listed.
- If dependent is disabled and coverage is being continued beyond the limiting age, attach proof of disability.
- From the appropriate provider directory, locate the **6-digit** office ID number for the primary care physician and/or dentist (if applicable). Indicate office ID number selection(s) on the form.
- If you are a current patient, check the "Current Patient" box(es) that apply.

Sections D, E and F – Health Questionnaire: Complete for employer group with no group medical coverage or a newly formed business with no group medical coverage.

Section G – Declination/Waiver of Coverage: Complete this section if declining coverage for any eligible employee and/or their eligible family members. Employee must sign and date.

Section H – Dependent Information: Complete this section for all new enrollments or coverage changes.

Section I – Coordination of Benefits: Complete this section for all new enrollments or coverage changes.

Section J – Conditions of Enrollment: Please read carefully.

Section K – Employee Signature:

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

Section L – Employer Verification:

- Employer must complete this section for all new enrollments, coverage changes and terminations.
- Employer must sign and date the Enrollment/Change Request form in order for it to be processed.

Additional Conditions and Instructions for Designation of Beneficiary

Conditions for Designation of Beneficiary

- **Please note:** The Group Contract grants the member the authority to designate a beneficiary. A beneficiary designated by someone other than the member (i.e., attorney-in-fact, Power of Attorney, guardian, custodian, etc.) may be barred under the Group Contract, by the Power of Attorney executed by the member and/or by state law. The member should execute the beneficiary designation section of this form whenever possible to ensure the designation is deemed valid.
- Unless otherwise expressly provided in the Designation of Beneficiary section of this form, if any named beneficiary predeceases me, the life proceeds shall be payable equally to the remaining named beneficiary or beneficiaries. If no named beneficiary survives me, any sum becoming payable under said Group Policy(ies) by reason of my death shall be payable as prescribed in said Group Policy(ies).
- If this Designation of Beneficiary provides for payment to a trustee under a trust agreement, Aetna Life Insurance Company shall not be obliged to inquire into the terms of the trust agreement and shall not be chargeable with knowledge of the terms thereof. Payment to and receipt by the trustee shall fully discharge all liability of said Insurance Company to the extent of such payment.
- If you live in one of the following community property states – Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin – your spouse may have a legal claim for a portion of the life insurance benefit under state law. If you name someone other than your spouse as beneficiary, payment of the death benefit may be delayed until your spouse's claim is resolved.

Instructions for Designation of Beneficiary

If these instructions do not answer all your questions, please contact your plan sponsor for assistance.

Please use only black ink to complete this form.

- If you make a mistake in completing this form, line out the erroneous information, add the correct information and initial the correction. **The printed material on this form should not be deleted or altered in any way.**
- **In all cases**, the relationship of the beneficiary, the beneficiary's Social Security Number, address and phone number should be included with the beneficiary designations.
- **Dollars and cents should not be specified**.
- If a minor child is named beneficiary, the child will not receive the benefits until age of majority.
- If a trustee is named beneficiary, show the exact name of the trust, date of the trust agreement, and the name and address of the trustee. **For example**, The John J. Smith Revocable Life Insurance Trust, dated January 1, 1994. John Smith, Trustee, 123 Apple Lane, Hartford, CT 06006.