New Jersey
Employee Enrollment/Change Form

Aetna Life Insurance Company **Aetna Health Inc.**
Aetna Health Insurance Company **Aetna Dental Inc.**

INSTRUCTIONS: You must complete this enrollment form in full. If you do not, we will return it to you, and that can delay its processing. You alone are responsible for its accuracy and completeness. **If you are declining coverage, you must complete section C.**

Employer group information – To be completed by employer	Aetna member ID number (if available)
Employer/company name – full name of business or organization	
Employer address (street, city, state, ZIP code) – primary location of business or organization	

A. Type of activity – Employee completes sections A – F. ***Please print clearly.***

Effective date / **Date of hire**			
	☐ New hire ☐ Rehire/reinstatement ☐ New group enrollment ☐ Late enrollment ☐ Waiver ☐ Open enrollment ☐ Loss of coverage	☐ Add spouse ☐ Add domestic partner ☐ Add civil union partner ☐ Add dependent child ☐ Change of coverage ☐ Name change	☐ Employee termination date _____ ☐ Remove spouse ☐ Remove domestic partner ☐ Remove civil union partner ☐ Remove dependent child ☐ Cancel coverage ☐ Other _____

☐ **COBRA** ☐ **State continuation** for: ☐ Employee ☐ Dependent Length of continuation: ☐ 18 months ☐ 36 months ☐ Other ____
Qualifying event _____ Original qualifying event date _____ Loss of coverage date _____

B. Employee information – ***You must complete this section.***

Social Security number	Last name, first name, middle initial		Job title
Home address	Apt. number	City, state	ZIP code
Work address		City, state	ZIP code
Home/cell telephone ( ) -	Work telephone ( ) -	Number of hours worked a week	Employee email
Primary language spoken (optional)	Check one: ☐ Full time ☐ Part time ☐ 1099 ☐ Retiree ☐ Seasonal ☐ Temporary ☐ COBRA ☐ Union		

C. Declining coverage – ***Check all that apply.***

I understand I am eligible to apply for this coverage through my employer. However, I am declining the coverage I checked below:

☐ Employee: ☐ Medical ☐ Dental ☐ Vision	**Reason for declining coverage**	☐ Insurance through another job
☐ Spouse/domestic partner/ civil union partner: ☐ Medical ☐ Dental ☐ Vision	☐ Parental group coverage	☐ TRICARE/Military coverage
☐ Children: ☐ Medical ☐ Dental ☐ Vision	☐ Spouse/domestic partner/civil union partner group coverage	☐ Individual coverage – On Exchange
	☐ Medicare	☐ Individual coverage – Off Exchange
	☐ Medicaid	☐ Another group plan provided by my employer
	☐ Retiree coverage	☐ Do not want
	☐ COBRA coverage	☐ Other _____

I certify I have the right to apply for this coverage. However, I am declining coverage as noted above. 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 and/or dependents.	***Date (Month/Day/Year)***
☐ I am declining coverage. **Employee signature:** X	
Please PRINT employee name:	

D. Plan Options – Check one plan. ***Your selection must be offered by your employer.***

Control number	Suffix	Account	Plan number	Customer Code

1. Medical ☐ Yes ☐ No *To enroll, check "yes" and enter the plan option elected below. Please print clearly.*

Plan option _____

You may only select a plan offered by your employer.

Aetna Life Insurance Company, Aetna Health Inc. and/or Aetna Health Insurance Company underwrite/administer medical coverage.

Control number	Suffix	Account	Plan number

2. Dental ☐ Yes ☐ No *To enroll, check "yes" and enter the plan option elected below. Please print clearly.*

Plan option/name _____

If Freedom-of-Choice (FOC), choose: ☐ Dental Maintenance Organization (DMO®) *or* ☐ Preferred Provider Organization (PPO)/Indemnity

You may only select a dental plan if your employer offers dental coverage.

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

Employees in AZ, CA, GA, MA, MD, MO, NC, NJ and TX must either live or work within the approved DMO® service area to be eligible to enroll in the DMO®.

For groups 51-100 only:

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? ☐ Yes ☐ No

Aetna Dental Inc. underwrites the Aetna DMO® plans. Aetna Life Insurance Company underwrites all other Aetna dental plans.

Control number	Suffix	Account	Plan number

3. Aetna Vision℠ Preferred ☐ **Yes** ☐ **No** *To enroll, check "yes" and enter the plan option elected below. Please print clearly.*

Plan option/name _____

You may only select a vision plan if your employer offers vision coverage.

Aetna Life Insurance Company underwrites Vision insurance plans. First American Administrators, Inc. provides certain claims administration services. EyeMed Vision Care, LLC ("EyeMed") provides certain network administration services.

E. Individuals covered – ***List individuals for whom you are enrolling or adding, changing or removing coverage. Please complete all information for all individuals. Add more sheets if needed.*** **NOTE FOR MEDICAL COVERAGE:** While the Affordable Care Act mandates coverage of dependent children up to age 26, your plan may allow coverage beyond age 26. Please refer to your plan documents or contact your benefits administrator. Enter domestic partner only if your employer has elected that coverage.

1	☐ Add ☐ Change ☐ Remove	**Employee name** (Last, first, middle initial)	Sex (M/F)

Birthdate (MM/DD/YYYY) / /	Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally separated	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision

Primary care physician (PCP) provider ID number	Current patient ☐ Yes	Dental provider office ID number	Current patient ☐ Yes

2	☐ Add ☐ Change ☐ Remove	**Name** (Last, first, middle initial) ☐ **Spouse** ☐ **Domestic partner** ☐ **Civil Union partner**	Sex (M/F)	Social Security number

Birthdate (MM/DD/YYYY) / /	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision

PCP provider ID number	Current patient ☐ Yes	Dental provider office ID number	Current patient ☐ Yes

3	☐ Add ☐ Change ☐ Remove	**Name** (Last, first, middle initial) ☐ **Child** ☐ **Stepchild** ☐ **Other** _____	Sex (M/F)	Social Security number

Birthdate (MM/DD/YYYY) / /	Incapacitated ☐ Yes ☐ No	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision

PCP provider ID number	Current patient ☐ Yes	Dental provider office ID number	Current patient ☐ Yes

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E. Individuals covered *(Continued)*

4	☐ Add ☐ Change ☐ Remove	**Name** (Last, first, middle initial) ☐ **Child** ☐ **Stepchild** ☐ **Other** _____		Sex (M/F)	Social Security number
Birthdate (MM/DD/YYYY) / /		Incapacitated ☐ Yes ☐ No		Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision	
PCP provider ID number		Current patient ☐ Yes		Dental provider office ID number	Current patient ☐ Yes

5	☐ Add ☐ Change ☐ Remove	**Name** (Last, first, middle initial) ☐ **Child** ☐ **Stepchild** ☐ **Other** _____		Sex (M/F)	Social Security number
Birthdate (MM/DD/YYYY) / /		Incapacitated ☐ Yes ☐ No		Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision	
PCP provider ID number		Current patient ☐ Yes		Dental provider office ID number	Current patient ☐ Yes

6	☐ Add ☐ Change ☐ Remove	**Name** (Last, first, middle initial) ☐ **Child** ☐ **Stepchild** ☐ **Other** _____		Sex (M/F)	Social Security number
Birthdate (MM/DD/YYYY) / /		Incapacitated ☐ Yes ☐ No		Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision	
PCP provider ID number		Current patient ☐ Yes		Dental provider office ID number	Current patient ☐ Yes

F. Dependent information

List any dependent in section **E** with a different last name or living at another address.

Name	Address

G. Coordination of benefits

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

If **yes**, will the Aetna coverage you're applying for replace the coverage you have now? ☐ Yes ☐ No

Name of person	Carrier name	Name of person	Carrier name

Conditions of enrollment

I acknowledge that by enrolling in an Aetna plan, coverage is underwritten or administered by Aetna Life Insurance Company, Aetna Health Inc., Aetna Health insurance Company and/or Aetna Dental Inc. (referred to as "Aetna"). For Vision coverage, First American Administrators, Inc. provides certain claims administration services. EyeMed Vision Care, LLC ("EyeMed") provides certain network administration services.

1. My employer's application determines coverage. I don't have coverage until Aetna approves my employee enrollment form and the employer application. Even if Aetna approves the employer application, material misstatements or omissions may result in denial of future claims. Aetna may rescind my coverage in case of fraud or intentional misrepresentation of material fact. Aetna may reevaluate my coverage under the policy, as of the effective date, for eligibility and rating purposes. If Aetna voids or rescinds coverage, I may be entitled to a refund of any paid premiums from the effective date of coverage. Aetna will give at least 30 days advance written notice to any covered person affected by the proposed rescission. If I elect to receive electronic notifications, I will receive this notice in an electronic (email) format.

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Conditions of enrollment *(Continued)*

2. To support the coverages listed on this enrollment form, Aetna may need information about medical history, services or treatment provided to anyone listed on this form. This may include minimally necessary information about mental health, substance use disorder and HIV/AIDS. To properly process claims, I authorize that the following entities can provide this information to Aetna or its agents:
   - Physicians
   - Other healthcare professionals
   - Hospitals
   - Any consumer reporting agency
   - Other healthcare organizations ("providers"), including
     - Pharmacies
     - Pharmacy database benefit managers
3. In accordance with HIPAA regulations, I authorize Aetna to use and disclose such minimally necessary information to:
   - Affiliates
   - Providers
   - Other insurers
   - Third party administration
   - Vendors
   - Consultants
   - Governmental authorities with jurisdiction when necessary for:
     - Care or treatment
     - Payment for services
     - Operation of my health plan
     - Conduct related activities
4. I discussed the terms of this authorization with my competent adult dependents. This authorization is valid for 30 months from the signature date. This authorization is valid for the term of the coverage for medical information collected in connection with a medical claim. This authorization is voluntary. But if I don't sign this form, my ability to enroll in the plan may be affected. I have the right to revoke this authorization in writing to Aetna at any time. I can't revoke authorization for information already used or disclosed before I revoked my authorization. I am entitled to receive a copy of this authorization upon request. A photocopy is as valid as the original.
   - The Group Agreement/Group Policy determines the rights and responsibilities of members and will govern in the event they conflict with any:
     - Benefits comparison
     - Summary
     - Other description of the plan
   - Participating physicians, hospitals and other health care providers are independent contractors. They are not Aetna agents or employees. We cannot guarantee the availability of any particular provider. Any provider network is subject to change. We will provide a notice of the change in accordance with applicable state law.
5. I understand that, with certain exceptions described in the plan documents, HMO and DMO© plans only provide coverage for covered benefits. The plan documents also describe if I need a referral for certain procedures, and who can provide care. Covered services must be performed by:
   - Participating primary care physicians
   - Participating primary care dentists
   - Participating specialists
   - Participating hospitals
   - Participating pharmacies
   - Participating dentists
   - Other participating providers as authorized by a referral from a participating primary care physician

Employee acknowledgement: I certify that all information and statements on this enrollment form are true and complete to the best of my knowledge. I have authority to make statements on behalf of any dependents listed on this form. I understand if I commit fraud or intentionally misrepresent material facts, coverage can be cancelled, or rates can be increased back to the effective date. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. I agree that my employer or its agent may send this form to Aetna.

I represent that all information supplied in this form is true and complete to the best of my knowledge and belief. I agree to the conditions of enrollment and misrepresentation statement on this Employee Enrollment Form. I understand that, if I don't sign this form within 31 days, or Aetna does not receive the request within a reasonable time, my eligibility may be affected. I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments required for coverage.

Misrepresentation: Any person who includes any false or misleading information on an enrollment/change form for a health benefits plan is subject to criminal and civil penalties.

To receive documents online, please visit your secure member account at aetna.com.

Please sign here ONLY if you are enrolling in coverage for yourself and/or dependents. ***Employee signature (required)*** **X**	***Date (Month/Day/Year)***