

Aetna™

New Jersey Small Group Enrollment/Change Request

Aetna Health Inc.

Employer Group Information - To Be Completed by Employer

Group Name		Medical - Control	Suffix	Account	Plan No.
		Dental - Control	Suffix	Account	Plan No.

A. Type of Activity - To Be Completed by Employer Refer to instructions on back before completing this form. Print clearly.

1. Enrollment	2. Change - Check all that apply	Date of Event	Reason	3. Remove or Terminate - Check all that apply.	Effective Date	Reason
<input type="checkbox"/> New Enrollee/Subscriber Effective Date: / / Date of Hire: / /	<input type="checkbox"/> Add Spouse <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 Office ID Numbers: Primary / Dentist	/ /		<input type="checkbox"/> Remove Spouse* <input type="checkbox"/> Remove Dependent Child* <input type="checkbox"/> Employee Withdrawal/Termination NOTE: Employee must be enrolled for spouse/dependent(s) to have coverage. * Please complete Add/Change/Remove and Name columns in Section D.	/ /	

B. Employee Information - Complete Sections B - H

Social Security Number	Last Name, First Name, MI.	Home Telephone	City, State	Zip Code	C. Plan Option - Your selection must be offered by your employer. Medical - Check One: <input type="checkbox"/> Aetna Primary Care™ Plan HMO <input type="checkbox"/> Aetna Choice™ Plan POS <input type="checkbox"/> Aetna Primary Care™ Plan HMO (with No Referrals) <input type="checkbox"/> Aetna Choice™ Plan POS (with No Referrals) <input type="checkbox"/> Mandated Plan Option (HMO \$15 Copy Option) <input type="checkbox"/> Primary Copy (Check One): <input type="checkbox"/> \$10 <input type="checkbox"/> \$15 <input type="checkbox"/> \$20 <input type="checkbox"/> \$30
Home Address	Apt. No.	City, State	Work Telephone	Zip Code	Dental - Check One: <input type="checkbox"/> Standard: <input type="checkbox"/> DMO <i>or</i> <input type="checkbox"/> PPO <input type="checkbox"/> Premier: <input type="checkbox"/> DMO <i>or</i> <input type="checkbox"/> PPO
Employer Name	City, State		Work Telephone	Zip Code	
Work Address	City, State	Zip Code			

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. Attach proof if full-time college student.

(A) Add (Change) (Remove)	Last Name, First Name, MI.	Sex	M	F	Birthdate	MM	DD	YYYY	Social Security Number	Other Health Coverage	Yes	No	Primary Office ID Number	Current Patient	Yes	No	Dentist Office ID Number (if applicable)	Current Patient	Yes	No
Employee			<input type="checkbox"/>	<input type="checkbox"/>	/ /					<input type="checkbox"/>				<input type="checkbox"/>				<input type="checkbox"/>		
Spouse			<input type="checkbox"/>	<input type="checkbox"/>	/ /					<input type="checkbox"/>				<input type="checkbox"/>				<input type="checkbox"/>		
Child			<input type="checkbox"/>	<input type="checkbox"/>	/ /					<input type="checkbox"/>				<input type="checkbox"/>				<input type="checkbox"/>		
Child			<input type="checkbox"/>	<input type="checkbox"/>	/ /					<input type="checkbox"/>				<input type="checkbox"/>				<input type="checkbox"/>		
Child			<input type="checkbox"/>	<input type="checkbox"/>	/ /					<input type="checkbox"/>				<input type="checkbox"/>				<input type="checkbox"/>		

E. Other Insurance

Is your Spouse Employed? Yes No If "Yes," give name & address of spouse's employer.

Does any dependent listed in Section D live at a different address than the Employee? If "Yes," who and what address? Yes No

G. Dependent Information

Explain the circumstances.

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

H. Employee Signature

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

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the reverse side of the employee copy of this application.

Employee Signature - Required X

Date: / /

I. Employer Verification - To Be Completed by Employer

Employee Signature - Required X

Date: / /

J. Pre-Existing Conditions Statement

NOTE: This information may ONLY be used to determine if a condition is a pre-existing condition. You CANNOT be denied coverage under a health benefit plan on the basis of inaccurate responses to the following questions. Carriers can only use the information to expedite the processing of claims.

1. During the past 6 months, have you or any dependent covered had or been diagnosed as having any of the following? If "Yes," check appropriate box(es) below.

<input type="checkbox"/> a. Alcoholism or Drug Abuse	<input type="checkbox"/> h. Heart Disorder or Condition or Chest Pain
<input type="checkbox"/> b. Arthritis	<input type="checkbox"/> i. High Blood Pressure
<input type="checkbox"/> c. Blood Disorder	<input type="checkbox"/> k. Kidney or Liver Disorder
<input type="checkbox"/> d. Back or Neck Disorder, Injury or Pain	<input type="checkbox"/> l. Lung or Respiratory Disorder
<input type="checkbox"/> e. Cancer or Tumors	<input type="checkbox"/> m. Mental or Nervous Disorder
<input type="checkbox"/> f. Diabetes	<input type="checkbox"/> n. Paralysis, Stroke or Epilepsy
<input type="checkbox"/> g. Gastro or Intestinal Disorder	

2. During the past 6 months, have you or any dependent to be covered:

a. been examined or treated by a physician or other health care provider for any condition, illness or injury, other than as stated above?
 b. been advised to have treatment or surgery or testing that has not been done?
 c. been admitted to a hospital or other health care facility as an inpatient?
 d. taken prescribed medications?

Yes No

Please give details for "Yes" answers to any part of Questions 1 or 2 on a separate sheet of paper. This separate sheet should be signed and dated.

Instructions

Employer

- Complete the **Employer Group Information** in the upper right corner of the form.
- **Section A - Type of Activity:** Check box(es) indicating reason(s) for submitting application.
- Complete **Section I - Employer Verification** in the lower right corner of the form.
- Employer must complete this section for all new enrollments, coverage changes and terminations.
- Employer must sign and date the application in order for it to be processed.

Employee - Complete Sections B - H.

Section B - Employee Information:

Complete all information in order for your application to be processed.

Section C - Plan Option:

- Check one Plan Option box for Medical and/or Dental coverage(s) (if applicable).
- Select only an option offered by your employer.

Section D - Individuals Covered:

- 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 dependent(s), if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
- If a dependent is a full-time college student, you **must** attach a current course schedule or a letter from the school confirming full-time student status (12 or more credits).
- If you or your dependent(s) have other Health coverage, check off the "Yes" box(es) and complete Section F - Other Insurance.
- 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, please check the "Current Patient" box.

Section E - Pre-Existing Conditions Statement:

Complete this section for all new enrollments. **Exception:** For Small Employer Group coverage, this section must be completed only by persons enrolling for coverage in a group of 2 - 5 employees, and to late entrants.

Section F - Other Insurance:

Complete this section for all new enrollments or coverage changes.

Section G - Dependent Information:

Complete this section for all new enrollments or coverage changes.

Section H - Employee Signature:

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

Section I - Employer Verification:

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

Conditions of Enrollment

Applicant Acknowledgments and Agreements

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

1. a) I authorize the sources stated below to give to Aetna Health 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.
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. 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 this 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 Health Inc. plan, coverage is provided by Aetna Health 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.
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.
5. Any person who includes any false or misleading information on an application or enrollment form for a health benefits plan is subject to criminal and civil penalties.

Misrepresentation