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.

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 _____

Effective Date ___/___/___

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.**

NOTE: 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.

Instructions

Employer

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

Employee – Complete Sections A – J

Section A – Type of Activity:

- Check boxes indicating reason(s) for submitting application.
- Employee must complete this section for all new enrollments, coverage changes and terminations.
- Employer must sign and date **Section L** of this Enrollment/Change Request form in order for it to be processed.

Section B – Medical Plan Options:

- Check one plan option box and indicate Plan Option Name (where applicable).
- Select only an option offered by your employer.

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

Section D – 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 being continued beyond the limiting age, attach proof of disability.
- If you or your dependent(s) have other Health or Rx drug coverage, check off the **Yes** box(es) and complete **Section I** - Other/Previous 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.
- You may obtain each 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.
- If you are a current patient, please check the "Current Patient" box.
- If you had previous coverage, please check the "Previous Coverage" box.

Section E – Race/Ethnicity (Optional): Check the appropriate Race/Ethnicity code for each individual. If your Race/Ethnicity is "Other," print the Race/Ethnicity for each individual in the space provided.

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

Section H – Other Insurance: Complete this section for all new enrollments or coverage changes. Coverage includes group coverage, governmental coverage, a church plan or Medicare.

Section I – Conditions of Enrollment: Please read carefully.

Section J – 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 K – 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.

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you are an existing Aetna member and need a qualified interpreter, written information in other formats, translation or other services, please call the number on your Aetna ID card. If you are a prospective Aetna member, please call 1-888-238-6201.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
PO Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,
or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

TTY: 711

For language assistance in your language call 1-888-238-6201 at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al 1-888-238-6201. (Spanish)

欲取得繁體中文語言協助，請撥打1-888-238-6201，無需付費。(Chinese)

Pour une assistance linguistique en français appeler le 1-888-238-6201sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-238-6201nang walang bayad. (Tagalog)

T'áá shí shizaad k'ehjí bee shíká a'doowoł nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-888-238-6201. (Navajo)

Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-238-6201 an. (German)

Për asistencë në gjuhën shqipe telefononi falas në 1-888-238-6201. (Albanian)

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للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-238-6201. (Arabic)

Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-888-238-6201առանց գնով: (Armenian)

Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-888-238-6201 ku busa. (Bantu-Kirundi)

Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-238-6201nga walay bayad. (Bisayan-Visayan)

বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1-888-238-6201-তে কল করুন। (Bengali-Bangala)

ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-888-238-6201 ကို ခေါ်ဆိုပါ။ (Burmese)

Per rebre assistència en (català), truqui al número gratuït 1-888-238-6201. (Catalan)

Para ayuda gi fino' (Chamoru), ågang 1-888-238-6201 sin gåstu. (Chamorro)

ᎾᏍᎩᎾ ᏕᏣᏓᏅᏛ ᏗᏂᏱᏍᎦ ᏢᏍᎩ ᎾᏓᎢ (ᏣᎳᎩ) ᏫᏏᏩᏛ Ꮥ 1-888-238-6201 ᎣᎾᎢ Ꮭ ᎪᎱᏍᏗ ᏧᎬᏩᎶᏗ ᏂᎨᏒᎾ. (Cherokee)

(Chahta) anumpa ya apela a chi I paya hinla 1-888-238-6201. (Choctaw)

Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-888-238-6201 irratti bilisaan bilbilaa. (Cushite)

Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-238-6201. (Dutch)

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-238-6201 gratis. (French Creole)

Για γλωσσική βοήθεια στα Ελληνικά **καλέστε το 1-888-238-6201 χωρίς χρέωση. (Greek)**

(Gujarati) ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર **1-888-238-6201** પર કોલ કરો.

No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-888-238-6201. Kāki ʻole ʻia kēia kōkua nei. (Hawaiian)

(Hindi) हिन्दी में भाषा सहायता के लिए, 1-888-238-6201 पर मुफ्त कॉल करें।

Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-238-6201. (Hmong)

Maka ènyemaka asụsụ na Igbo kpọọ 1-888-238-6201 na akwụghị ụgwọ ọ bụla (Ibo)

Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-238-6201 nga awan ti bayadanyo. (Ilocano)

Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-238-6201 tanpa dikenakan biaya. (Bahasa Indonesia)

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-238-6201. (Italian)

日本語で援助をご希望の方は、1-888-238-6201 まで無料でお電話ください。(Japanese)

လာတ်မၤစၢၤတ်ကတိၤကျိာ်အဂီၢ် ကျိာ် ကိး 1-888-238-6201 လၢတအိာ်ဒီးတ်လၢာ်ဘျာ်လၢာ်စုၤဘဉ် (Karen)

한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-238-6201 번으로 전화해 주십시오. (Korean)

Bɛ̀ m̀ ké gbo-kpá-kpá dyé pídyi ɖé Bǎsɔ́ɔ̀-wùɖùǔn wɛ̃ɛ, ɖá 1-888-238-6201 (Kru-Bassa)

بۆ وەرگرتنی ڕێنوێنی پێوەندیدار بە زمان بە زمان بە ژمارەی 1-888-238-6201 بە خۆڕایی پەیوەندی بکەن. (Kurdish)

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-888-238-6201 ໂດຍບໍ່ເສຍຄ່າໂທ. (Laotian)

तील भाषा (मराठी) सहाय्यासाठी 1-888-238-6201 क्रमांकावर कोणत्याही खर्चाशिवाय कॉल करा. (Marathi)

Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-238-6201 ilo ejjelok wōnān. (Marshallese)

Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-238-6201ni sohte isais. (Micronesian-Pohnpeian).

សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-888-238-6201 ដោយឥតគិតថ្លៃ។ (Mon-Khmer, Cambodian)

(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-888-238-6201 मा फोन गर्नुहोस्। (Nepali)

Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-888-238-6201 kecïn aɣöc. (Nilotic-Dinka)

For språkassistanse på norsk, ring 1-888-238-6201 kostnadsfritt. (Norwegian)

Fer Helfe in Deitsch, ruf: 1-888-238-6201aa. Es Aaruf koschtet nix. (Pennsylvanian Dutch)

برای راهنمایی به زبان فارسی با شماره 1-888-238-6201 بدون هیچ هزینه ای تماس بگیرید. انگلیسی (Persian)

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-238-6201. (Polish)

Para obter assistência linguística em português ligue para o 1-888-238-6201 gratuitamente. (Portuguese)

(Punjabi) ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-238-6201'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।

Pentru asistenţă lingvistică în româneşte telefonaţi la numărul gratuit 1-888-238-6201(Romanian)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-238-6201. (Russian)

Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-888-238-6201 e aunoa ma se totogi. (Samoan)

Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-888-238-6201. (Serbo-Croatian)

Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-888-238-6201. Njodi woo fawaaki on. (Sudanic-Fulfulde)

Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-238-6201 bila malipo. (Swahili)

ܐܢ ܟܚܐ ܐܝܬ ܠܟ ܡܬܪܓܡܢܘܬܐ ܒܠܫܢܐ ܣܘܪܝܝܐ
ܩܪܝ ܠܗ ܡܢܝܢܐ ܕܠܐ ܦܠܛܐ 1-888-238-6201 ܡܓܢܐ. (Syriac-Assyrian)

భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-888-238-6201 కాల్ చేయండి. (తెలుగు) (Telugu)

สำหรับความช่วยเหลือทางด้านภาษาเป็นภาษาไทย โทร 1-888-238-6201 ฟรีไม่มีค่าใช้จ่าย (Thai)

Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-888-238-6201 'o 'ikai hā tōtōngi. (Tongan)

Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-238-6201 nge esapw kamé ngonuk. (Trukese-Chuukese)

(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-888-238-6201. (Turkish)

Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-238-6201. (Ukrainian)

اُردو میں لسانی معاونت کے لیے 1-888-238-6201 پر مفت کال کریں۔ (Urdu)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-888-238-6201. (Vietnamese)

פאר שפראך הילף אין אידיש רופט 1-888-238-6201. פריי פון אפצאל. (Yiddish)

Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-888-238-6201 lái san owó kankan rárá. (Yoruba)