New Jersey Enrollment/Change Request
Aetna Health Inc.

Employer Group Information - To Be Completed by Employer

Group Name	Group Number	Class Code
SNJ Employee Benefits Fund	030217	

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

1. Enrollment

☐ New Enrollee/Subscriber

Effective Date ___/___/___

Date of Hire ___/___/___

2. Change - *Check all that apply.*

	Date of Event	Reason
☐ Add Spouse	___/___/___	
☐ Add Domestic Partner	___/___/___	
☐ Add Dependent Child	___/___/___	
☐ Name Change	___/___/___	
☐ Change Plan	___/___/___	
☐ Other	___/___/___	

☐ Add/Change **Primary** Office ID Number

3. Remove or Terminate - *Check all that apply.*

	Effective Date	Reason
☐ Remove Spouse*	___/___/___	
☐ Remove Domestic Partner*	___/___/___	
☐ Remove Dependent Child*	___/___/___	
☐ 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.

4. Continuation of Coverage, i.e. COBRA, State, Total Disability - *Not all options are available or applicable. Contact Employer for available options.*

Coverage For: ☐ Employee ☐ Dependents

Length of Continuation: ☐ 12 mos ☐ 18 mos ☐ 29 mos ☐ 36 mos

☐ Total Disability - Attach proof of total disability

Date of Loss of Coverage: ___/___/___

Date of Qualifying Event: ___/___/___

B. Employee Information - Complete Sections B - G.

Last Name, First Name, M.I.	Social Security Number	Home Telephone ( )

Home Address	Apt. No.	City, State	ZIP Code

Employer Name	Email Address	Work Telephone ( )	Date of Employment:	Hours Worked Per Week:

Work Address	City, State	ZIP Code

C. Plan Option - Your selection must be offered by your employer.

Check One:

☐ HMO ☐ QPOS® ☐ USAccess®

☐ Aetna Open Access™ HMO

☐ Aetna Choice™ POS

Indicate Plan Name

Primary Copay:

☐ $5 ☐ $10 ☐ $15 ☐ Other $ ____

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

	(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex M	Sex F	Birthdate MM DD YYYY	Social Security Number	Other Health Coverage Yes	Other Rx Drug Coverage Yes	Primary Office ID Number	Current Patient Yes	Previous Coverage Check if yes
Employee			☐	☐	/ /		☐	☐		☐	☐
Spouse			☐	☐	/ /		☐	☐		☐	☐
Domestic Partner			☐	☐	/ /		☐	☐		☐	☐
Child			☐	☐	/ /		☐	☐		☐	☐
Child			☐	☐	/ /		☐	☐		☐	☐
Child			☐	☐	/ /		☐	☐		☐	☐

E. Other/Previous Insurance

Is your Spouse Employed? ☐ Yes ☐ No If "Yes," give name & address of your spouse's employer.	If "Yes" to Other Rx Drug Coverage (Section D), give name & policy number of insurance carrier, HMO, or other source.
If "Yes" to Other Health Coverage (Section D), give names & policy numbers of insurance carrier, HMO, or other source. If enrolled in Medicare Parts A and/or B identify the coverage and provide the Medicare ID number.	If "Yes" to Previous Coverage, identify name(s) of persons, give effective date and date coverage terminated, name of previous carrier and plan number and submit a copy of the Certificate of Creditable Coverage that was issued by the previous carrier, if available.

F. Dependent Information

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

Explain the circumstances.

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

G. Employee Signature

*If you have questions concerning the benefits and services provided by or excluded under this Agreement, contact a Member Services representative at **1-800-323-9930** before or after 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 this Enrollment/Change Request. I authorize deductions from my earnings for any required contributions.

Employee Signature - *Required*
X

Date ___/___/___

E-Mail Address

H. Employer Verification - To Be Completed by Employer

Employer Signature - *Required*
X

Title

Date ___/___/___

Employee copy may be used as a temporary ID card for 30 days from the effective date if authorized by employer. Coverage must be verified with Aetna Health Inc. prior to visiting a specialist or admission to a hospital.