aetna℠

New Jersey Small Group Life, Disability, and Dental Enrollment/Change Request

Aetna Dental Inc. /Aetna Life Insurance Company

Life, Accidental Death & Dismemberment, and Disability plans are underwritten by Aetna Life Insurance Company. DMO and Voluntary DMO coverage is underwritten by Aetna Dental Inc. All other dental coverage is provided by Aetna Life Insurance Company.

Employer Group Information - To Be Completed by Employer: (Please complete if a current Aetna customer.)

Group Name			
Life - Control	**Suffix**	**Account**	**Plan No.**
Disability - 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

☐ New Enrollee/Subscriber

Effective Date / /

Date of Hire / /

2. Change - *Check all that apply.*

	Date of Event
☐ Add Spouse	/ /
☐ Add Civil Union Partner	/ /
☐ Add Domestic Partner	/ /
☐ Add Dependent Child	/ /
☐ Name Change	/ /
☐ Change Plan	/ /
☐ Other	/ /

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

	Effective Date
☐ Remove Spouse*	/ /
☐ Remove Civil Union Partner*	/ /
☐ 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.

B. Employee Information - Complete Sections B - H.

Social Security Number	Last Name, First Name, M.I.			Home Telephone ( )
Home Address	Apt. No.	City, State		ZIP Code
Employer Name		Date of Employment	Hours Worked Per Week	Work Telephone ( )
Work Address		City, State		ZIP Code

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

1. Life and Disability

☐ Basic Life/AD&D Ultra™
☐ Optional Dependent Life
☐ Life & Disability Packaged Plan
☐ Other _____

Beneficiary Designation - **Full Name** (First, Middle, Last)

Beneficiary Social Security Number | Relationship to Employee

2. Dental - To enroll, enter plan number and name of your election below.

Contributory Plans: Option Number: _____ Plan Option Name: _____

Voluntary Plans: Option Number: _____ Plan Option Name: _____

If your employer has 25 or more employees and you are offered DMO, you must also be offered one of the PPO/PPO Max plans. If your employer has 3 or more employees and you are offered Voluntary DMO, you must also be offered Voluntary PPO/PPO Max.

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

D. Individuals Covered - List individuals whom you are enrolling or adding/changing/removing for Life and/or Dental coverage.

Please Note: Disability is only available for the employee.

	(A)dd **(C)**hange **(R)**emove	**Last Name, First Name, M.I.**	**Sex** M F	**Birthdate** MM DD YYYY	**Social Security Number**	**Coverage Election**	**Previous Dental Coverage**	**Previous Disability Coverage - for Employees Only**	**Other Dental Coverage**	**Dentist Office ID Number** (if applicable)	**Current Patient**
Employee			☐ ☐	/ /		☐ Life/Dis ☐ Dental	Yes ☐	Yes ☐	Yes ☐		Yes ☐
Spouse/ Civil Union Partner			☐ ☐	/ /		☐ Life ☐ Dental	☐	N/A	☐		☐
Domestic Partner			☐ ☐	/ /		☐ Life ☐ Dental	☐	N/A	☐		☐
Child			☐ ☐	/ /		☐ Life ☐ Dental	☐	N/A	☐		☐
Child			☐ ☐	/ /		☐ Life ☐ Dental	☐	N/A	☐		☐
Child			☐ ☐	/ /		☐ Life ☐ Dental	☐	N/A	☐		☐

E. Dependent Information

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

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

F. Declination/Waiver of Coverage - *To be completed if life, disability, or dental coverage is declined or refused by an eligible employee and/or their eligible family members.*

1. Life Coverage Declined for:
☐ Employee ☐ Spouse/Civil Union Partner
☐ Children ☐ Domestic Partner

2. Disability Coverage Declined for:
☐ Employee

3. Dental Coverage Declined for:
☐ Employee ☐ Spouse/Civil Union Partner
☐ Children ☐ Domestic Partner

Reason for Refusal - Please check all appropriate boxes. *(If applicable, please attach front/back of your coverage ID card(s).)*
☐ Other group coverage sponsored by my employer.
☐ Other group coverage sponsored by my spouse's/civil union partner's/domestic partner's employer.
☐ Other group coverage by another organization.
☐ Other (please explain): _____

Please provide name of carrier and policy number.

I was given the opportunity to enroll in these plans of group life, disability, and dental benefits offered by my employer and underwritten by Aetna Life Insurance Company and Aetna Dental Inc.; however, I refuse the above coverage(s). I understand that if I later wish to enroll for any of the coverage(s) refused, I will be required to submit an Enrollment Request.

Please sign here ONLY if you are declining coverage for yourself or dependent(s).	*Date (Month/Day/Year)*
X Employee Signature	
X Witness Signature	*Date (Month/Day/Year)*

G. 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 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. Authorized sources are: 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 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 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 Life Insurance Company and/or Aetna Dental Inc. plans, coverage is provided by 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 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 application for a coverage policy is subject to criminal and civil penalties.

H. Employee Signature

If you have questions concerning the benefits and services provided by or excluded under this Plan, contact a Member Services representative at 1-888-802-3862 before or after signing this form.

I certify that all statements made on 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. I authorize deductions from my earnings for any required contributions.

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

I. Employer Verification - To Be Completed by Employer

Employer Signature - *Required*	**Title**	***Date (Month/Day/Year)***
X		

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** at the bottom of Page 2.
  - Employer must complete this section for all new enrollments, coverage changes and terminations.
  - Employer must sign and date the enrollment/change request 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. If employee is declining coverage, complete Sections B and G.

Section C - Plan Option:

- Check one plan option box for Life/Disability selection and/or enter plan number and name for Dental selection (if applicable).
- Select only an option offered by your employer.
- Please fill out complete name of Beneficiary: First, Middle Initial, Last. Fill in Social Security Number and Relationship.

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.

Section E - Dependent Information:

Complete this section for all new enrollments or coverage changes.

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; a witness must sign and date.

Section G - Conditions of Enrollment:

Read this section carefully.

Section H - Employee Signature:

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