New Jersey Enrollment/Change Request
Aetna Life Insurance Company

Employer Group Information - To Be Completed by Employer

Group Name	Control	Suffix	Account	Plan No.
Rider University	884014			

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:

☐ Elect Choice® EPO	☐ Aetna Open Access™ Elect Choice	☐ Aexcel℠
☐ Manage Choice® POS	☐ Aetna Open Access™ Managed Choice	☐ Aexcel℠ Plus
☐ Aetna Choice™ POS II	☐ Open Choice® PPO	☐ HMO (IMO Use Only)
☐ Aetna HealthFund™	☐ Traditional Choice®	☐ 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.

Relationship Code	(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	Other RX Drug Coverage	Primary Office ID Number	Current Patient	Previous Coverage Check if yes
Employee			☐	☐	/ /		Yes ☐	Yes ☐		Yes ☐	Yes ☐
			☐	☐	/ /		☐	☐		☐	☐
			☐	☐	/ /		☐	☐		☐	☐
			☐	☐	/ /		☐	☐		☐	☐
			☐	☐	/ /		☐	☐		☐	☐
			☐	☐	/ /		☐	☐		☐	☐

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 ___/___/___

Instructions

Employer

- Complete the **Employer Group Information** in the upper right corner of the form.
- **Section A - Type of Activity:**
  - Check boxes indicating reason(s) for submitting Enrollment/Change Request.
- Complete **Section H - 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 Enrollment/Change Request in order for it to be processed.

Employee - Complete Sections B - G.

Section B - Employee Information:

Complete **all** information in order for your Enrollment/Change Request to be processed.

Section C - Plan Option:

- Check one Plan Option box.
- Select only an option offered by your employer.

Section D - Individuals Covered:

- Relationship Code - Use **ONLY**: H=Husband, W=Wife, N=Divorced Spouse, S=Son, D=Daughter, Y=Sponsored Male or Domestic Partner, X=Sponsored Female or Domestic Partner. **If the dependent is NOT a biological or legally adopted child, please indicate relationship to employee.**
- 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, Birthdate, and Social Security Number for each individual listed.
- If a dependent is a full-time post secondary student, you **must** attach a current course schedule or a letter from the school or its authorized representative confirming full-time student status (12 or more credits) 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 E - Other/Previous Insurance.
- From the appropriate provider directory, locate the office 6 digit ID number for the primary care physician. Indicate office ID number selection on the form.
- If you are a current patient, please check the "Current Patient" box.

Section E - Other/Previous Insurance:

Complete this section for all new enrollments or coverage changes. Coverage includes group coverage, governmental coverage, a church plan or Medicare.

Section F - Dependent Information:

Complete this section for all new enrollments or coverage changes.

Section G - Employee Signature:

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

Section H - Employer Verification:

- 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.

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, 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 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 the authorization is as valid as the original.
2. I acknowledge by enrolling in an Aetna Life Insurance Company 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.