



New Jersey Employee Enrollment/Change Request For Employer Groups with 101 or More Employees Aetna Dental Inc. / Aetna Life Insurance Company

Aetna DMO® and Advantage/Basic Dental Options are provided by or administered by Aetna Dental, Inc. and all other dental coverage is provided by or administered by Aetna Life Insurance Company.

Member Aetna ID Number (if available)

Employer Name MONROE TOWNSHIP BOARD OF EDUCATION	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 clearly.

1. Enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> Rehire/Reinstatement <input type="checkbox"/> New Group Enrollment <input type="checkbox"/> Late Enrollment <input type="checkbox"/> Other _____ Effective Date: ____/____/____ Date of Hire: ____/____/____		2. Change – Check all that apply. <input type="checkbox"/> Change of Coverage <input type="checkbox"/> Add Spouse/Civil Union/ Domestic Partner/Dependent Child <input type="checkbox"/> Name Change <input type="checkbox"/> Other <input type="checkbox"/> 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. <input type="checkbox"/> Employee Termination <input type="checkbox"/> Remove Spouse/Civil Union/ Domestic Partner/ Dependent Child* <input type="checkbox"/> 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. <input type="checkbox"/> COBRA <input type="checkbox"/> State Continuation <input type="checkbox"/> Total Disability Coverage for: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse/Civil Union/Domestic Partner* <input type="checkbox"/> Dependent(s) Length of Continuation: <input type="checkbox"/> 18 mos. <input type="checkbox"/> 29 mos. <input type="checkbox"/> 36 mos. <input type="checkbox"/> 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. Dental Plan Options – Your selection must be offered by your employer.

Control/Group No.	Suffix	Account	Plan No.	Class Code
Check One.				
<input type="checkbox"/> Indemnity Dental – Plan Option: _____ <input type="checkbox"/> DentalFund/HealthFund – Plan Option: _____ <input checked="" type="checkbox"/> Dental PPO – Plan Option: PPO/PDN WITH PPO II <input type="checkbox"/> Dental EPP – Plan Option: _____ <input type="checkbox"/> DMO®/Advantage/Basic – Plan Option: _____ <input type="checkbox"/> FOC/Indemnity – Plan Option: _____ <input type="checkbox"/> FOC/PPO – Plan Option: _____ <input type="checkbox"/> FOC/DMO – Plan Option: _____				

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
Salary \$	<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	No. of Hours Worked Per Week	Check One: <input type="checkbox"/> Full-Time <input type="checkbox"/> 1099 <input type="checkbox"/> Seasonal <input type="checkbox"/> COBRA <input type="checkbox"/> Part-Time <input type="checkbox"/> Retired <input type="checkbox"/> Temporary <input type="checkbox"/> Union	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Civil Union Partner <input type="checkbox"/> Single <input type="checkbox"/> 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) Add (C) Change (R) Remove	Last Name, First Name, M.I.	Sex M/F	Social Security Number	Birthdate			Disabled	Late Enrtrant	Other Dental Coverage	Dental Office ID Number (if applicable)		Current Patient	Previous Coverage Check if "Yes"
				MM	DD	YYYY				NPI Number			
	1. Employee						Yes N/A	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Office NPI	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	
	2. Spouse/Civil Union/Domestic Partner						N/A	<input type="checkbox"/>	<input type="checkbox"/>	Office NPI	<input type="checkbox"/>	<input type="checkbox"/>	
	3. Child						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Office NPI	<input type="checkbox"/>	<input type="checkbox"/>	
	4. Child						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Office NPI	<input type="checkbox"/>	<input type="checkbox"/>	

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. <input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02 <input type="checkbox"/> Hispanic or Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____	Child 3. <input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02 <input type="checkbox"/> Hispanic or Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____
Spouse/Civil Union/Domestic Partner 2. <input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02 <input type="checkbox"/> Hispanic or Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____	Child 4. <input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02 <input type="checkbox"/> Hispanic or Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____

F. Declination/Waiver of Coverage - To be completed if 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 dental coverage

I was given the opportunity to enroll in the dental plan offered by my employer and underwritten by Aetna Dental Inc. and/or 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). Date (Month/Day/Year)

Employee Signature

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/Previous Insurance

If you have checked "Yes" to Other Dental Coverage (Section D), 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. _____

PROOF OF PRIOR DENTAL COVERAGE - IMPORTANT (Required)

Does anyone age 19 or over enrolling on this enrollment form have prior coverage? Yes No

If "Yes," provide the information requested in the table below.

Proof of coverage should accompany this enrollment form for pre-existing condition credit if enrolling in other than an HMO plan. **Acceptable forms of proof are:**

1. Certificate of Creditable Coverage from prior carrier, or
2. Copy of ID card or most recent payroll stub showing coverage deduction, or
3. Copy of most recent premium bill from prior carrier.

Failure to provide Proof of Prior Coverage may subject you or a family member (age 19 or over) to the full pre-existing conditions limitation with no credit for prior coverage. You may request a Certificate of Creditable Coverage from your prior carrier.

NOTE: If your Plan contains a pre-existing conditions provision, the pre-existing conditions exclusion and limitation will not apply to a person under 19 years of age.

Name of Covered Individual	Carrier Name	Group Number	Start Date	Termination Date	Dental
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> 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 Dental Inc. and/or 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 Dental Inc. and/or 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 Dental Inc. and/or 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 Dental Inc. and/or 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.

<i>Employee Signature - Required</i>	<i>Employee E-mail Address (optional)</i>	<i>Date (Month/Day/Year)</i>
X		

K. Employer Verification – To be completed by Employer

<i>Employer Signature – Required</i>	<i>Title</i>	<i>Date (Month/Day/Year)</i>
X	BENEFITS COORDINATOR	

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 Dental Inc. or 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.

Monroe Township Board of Education

Cardmember Information

First Name _____ Last Name _____ Employee Number _____
 Mailing Address _____ City _____ State _____ Zip Code _____

Phone Number _____ Cell Phone Number _____ Email Address _____

Coverage Type

Single _____ Family _____ Active Employee _____ COBRA _____

Reason Code

A	New Enrollment	E	Group Change - Single to Family
B	Reinstate Member	F	Group Change - Family to Single
C	Reinstate Dependent	G	Terminate Coverage
D	Add Dependent	H	Terminate Dependent Coverage

Eligibility

	LAST NAME	FIRST NAME	GENDER	BIRTHDATE	REASON CODE
CARDMEMBER					
DEPENDENT SPOUSE					
DEPENDENT 1					
DEPENDENT 2					
DEPENDENT 3					
DEPENDENT 4					

Signature

MEMBER SIGNATURE _____ DATE _____