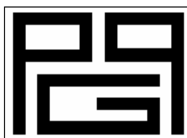

PROFESSIONAL GROUP PLANS, INC.
Specializing in Employee Benefits

Aetna Healthcare
New Jersey
New Business Submission
Checklist

___ Installation Checklist

___ Employer Application Form- NJ

___ Certification Form

___ Employee Enrollment Form(s)

___ Waiver Form(s)

___ Signed Quote or Rate Sheet

___ WR-30 Form

___ First Month's Premium Check Payable to :
Aetna

___ Forms Must Be Submitted to PGP Office
*6 days prior to the effective date.

If you have any questions, please contact your PGP representative.

Updated 1/2/04

225 Wireless Blvd., 2nd Fl. • Hauppauge, New York 11788 • Tel: 631.951.9200 • Fax: 631.951.9623 • www.pgpbenefits.com

New Business Case Submission Checklist

Northern New Jersey

For assistance with your new case submissions, contact our broker sales support center at 1-888-277-1053, prompt #5

Broker Name: ______________________________ Agency Name: ______________________

For questions on this submission, please contact: ______________________________________

Phone: (_____) _________ - _________________ Fax#: (_____) _________ - ______________

Email address: ___________________________ GA contact (if applicable): __________________

Prospect/Client Name: ________________________ Prospect email address: ___________________

Step 1
Complete/review Employer Application

- ❑ **1. HMO/QPOS Application:**
  www.aetna.com/producer/data/sbc/nj_employer_application.pdf
- ❑ **2. Dental/Life Application:**
  www.aetna.com/producer/data/sbc/nj_er_life_prod.pdf
- ❑ **3. NJ Small Group Verification Certificate**
  www.aetna.com/producer/data/sbc/nj_er.pdf
- ❑ **4. WR-30 or other applicable tax documents**
  (Proof of Eligibility Form, if owner/officer/partner not on tax form)
  www.aetna.com/producer/data/sbc/Proof_of_Eligibility.pdf
- ❑ **5. Premium check made payable to Aetna, Inc.**
- ❑ **6. Copy of current/prior medical carrier's latest bill with employee roster & premium summary page**

Step 2
Complete/review Employee Information

- ❑ **1. Employee Enrollment Form for each employee**
  HMO/QPOS/Dental-
  www.aetna.com/producer/data/sbc/EE_Enrollment_form_NewJersey.pdf
  Group Insurance (Life & Packaged Life/Disability Product)
  www.aetna.com/producer/data/sbc/NJGrp_Ins_Enr_Form.pdf
- ❑ **2. Individual Waiver Form filled out completely for each employee waiving coverage**
  www.aetna.com/producer/data/sbc/nj_eew.pdf

Step 3
Complete/review Broker Information

- ❑ **1. Illustrative rates & copy of census (Employee Listing Report) from Aetna rating tool**
- ❑ **2. Agent/broker must be licensed in state & appointed by Aetna**

Detailed Submission Guidelines Attached.

Effective dates may be the **first or fifteenth of the month only**. All required paperwork must be received by Aetna at least **three business days** prior to the requested effective date.

Send all information to

Aetna Small Group
New Case Submissions
One Farr View
Cranbury, NJ 08512

We want you to know℠

Aetna®

Submission Details & Guidelines
Northern New Jersey

Avoid potential delays in getting your client enrolled.

Make sure your new case submissions are complete!

Employer Information

✓ **Employer Application**

a. Employer signature must be an owner or corporate officer

b. Number of eligible and enrolled employees

c. Premium percentage paid by employer

d. Indicate selected products in Section II- Specifications for Coverage

e. Complete grid for any employee/dependent health continuations (COBRA, state continuation)

f. Applications will not be accepted more than 60 days from date signed

✓ **WR-30 or other applicable tax documents**

a. Out-of-state employees require proof of employment if not identified on WR-30

b. If owner, partner, or corporate officer not listed on WR-30, submit the Small Group Proof of Eligibility Form signed by employees & with requested documents

c. If newly hired employees are not identified on the WR-30, submit payroll report indicating compensation & taxes withheld.

Employer Information Cont…

✓ **Premium check made payable to Aetna, Inc.**

a. Company check required

✓ **Copy of current/prior medical carrier's latest bill**

a. Include employee roster & premium summary page

Employee Information

✓ **Employee applications filled out by each employee**

a. Any alterations must be initialed and dated by employee.

b. Individual Waiver Form completely filled out for each employee waiving coverage

Dental Submissions*

a. Employer Master Application

b. Employee Enrollment Form

c. First Month Premium Check Required (on company check stock)

Group insurance & dental may be submitted on one check

d. Copy of illustrative dental rates & census

Group Insurance Submissions*

a. Employer Master Application

b. Employee Enrollment Form

c. First Month Premium Check Required (on company check stock)

Group insurance & dental may be submitted on one check

d. Copy of illustrative life rates & census if term life selected

e. Individual Health Statement required if selecting life amount in excess of Guaranteed Issue amount

* If submitting standalone dental or life submission, tax documents and copy of prior carrier's bill are also required

"Aetna" is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies.

This material is for informational purposes only and is subject to change..

We want you to know℠

Aetna®

APPLICATION FOR A SMALL GROUP HEALTH BENEFITS POLICY

Please Print or Type	For Aetna Use Only
☐ New Policy ☐ Change in Policy Requested Effective Date ______ **NOTE:** The Effective Date will be on or after the date Aetna approves the application.	Policy Number ______

Section I: POLICYHOLDER INFORMATION

1. Policyholder (Full Legal Name of Company)

2. Tax Identification Number

3. Main Address | City | State | Zip

Mailing Address | City | State | Zip

Telephone Number ( ) | Facsimile Number ( )

4. Name of Correspondent | Telephone

5. Type of Organization
☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Other (explain):

6. Nature of Business (specify) | SIC Code

7. Number of eligible employees in your company

Refer to the New Jersey Small Employer Certification for the definition of an eligible employee

8. Number eligible employees to be insured

9. Class or classes to be excluded

10. Insurance requested for
☐ Employees Only ☐ Employees and Dependents
Should the plan provide coverage for domestic partners as permitted by P.L. 2003, c.246? ☐ Yes ☐ No
If "Yes", should the plan provide coverage for coverage of children of covered domestic partners? ☐ Yes ☐ No

11. Is the Employer subject to the requirements of COBRA?
☐ Yes ☐ No

12. Is the employer subject to the requirements of Medicare as Secondary Payor Rules for eligibility due to
age? ☐ Yes ☐ No
disability? ☐ Yes ☐ No

13. Waiting period before employees become insured (may not exceed 6 months):
Present Employees: ______
New or Rehired Employees: ______

14. What percentage of the premium will the employer pay?

15. Deposit
$ ______ Premium Paid: Monthly

Premium will be due as of the effective date.
The premium for the first month of coverage must be attached.

Affiliates, subsidiaries or branches (Must be included for the purposes of participation)

Legal Name and Location	No. Eligible Employees In This Company	No. Eligible Employees to Be Insured

Section II: SPECIFICATIONS FOR COVERAGE

Health Benefits: Plan number (1, 2, etc.) and suffix (N or S) must be completed below.

☐ NJ HMO: Plan Option - ________
Suffix *(please circle one)*: N or S

☐ NJ HMO No-Referral: Plan Option - ________
Suffix *(please circle one)*: N or S

☐ NJ Cost-Sharing HMO: Plan Option - ________
Suffix *(please circle one)*: N or S

☐ NJ POS No-Referral: Plan Option - ________
Suffix *(please circle one)*: N or S

☐ Out-of-Region PPO: ☐ $250 (High) ☐ $500 (Medium) ☐ $1000 (Low)

☐ State Mandated Plans:
– NJ HMO: ☐ $5 Plan ☐ $10 Plan ☐ $15 Plan ☐ $20 Plan ☐ $30 Plan
– NJ Indemnity: ☐ Plan A1 ☐ Plan A2 ☐ Plan B ☐ Plan C ☐ Plan D ☐ Plan E1 ☐ Plan E2

☐ Other Plan ________________________________

Section III: ALL QUESTIONS MUST BE ANSWERED

1. Is there any Group Health Plan:
   - now in force and to be continued? ☐ Yes ☐ No
   - currently being applied for? ☐ Yes ☐ No

   If "Yes", identify the name of the Group Health Plan, give a description of the plan(s) and the name of insurance carrier(s):
   ____
2. Name of present or prior group carrier ________________________________
   Effective date of prior coverage ____________________ Cancellation/Termination Date ____________________
   Is the coverage applied for in this application replacing other group insurance? ☐ Yes ☐ No
   If "Yes" give reason ________________________________
   Plan being replaced ☐ A ☐ B ☐ C ☐ D ☐ E ☐ HMO ☐ HMO/POS ☐ Dual Contract POS ☐ Other ____________________
3. Has your firm been uninsured for 3 or more months prior to application? ☐ Yes ☐ No
4. What forms of Insurance are now or were in force? ☐ Health Benefits ☐ Prescription Drugs
   (Attach copies of Booklet/Certificate and most recent Billing Statement.)
5. Are extended benefits provided in case of termination of health benefits? ☐ Yes ☐ No
6. To the best of your knowledge, are there any current or former employees or their eligible dependents whose health insurance is being continued? ☐ Yes ☐ No

   Please provide the following information for each current/former employee or dependent on health continuations.
   If additional space is needed, attach a separate sheet, signed and dated.

Name of Employee/ Dependent	Date of Birth	Type of Continuation State/Federal/ Extended Benefits	Reason for Termination Disability/Other	Continuation Dates	
				Start	End

7. To the best of your knowledge:
   a. Are any employees or dependents presently incapacitated? ☐ Yes ☐ No
   b. Are any dependent children incapable of self-support due to a physical or mental disability? ☐ Yes ☐ No

   Additional space to explain if items 1, 2 or 3 were answered "Yes". Refer to the question number, and give details, including names, where appropriate.

   ____
   ____
   ____
   ____
   ____
   ____
8. Does the employer participate in an arrangement with a Professional Employer Organization? ☐ Yes ☐ No
   (Refer to Advisory bulletin 00-SEH-02 if you need information concerning what constitutes a Professional Employer Organization.)

Section IV: AGENT/PRODUCER INFORMATION

Agent/Broker Name: ______________________ Aetna Agent Number/Tax ID/SSN: ______________________

Agency Name: ______________________ % of Credit: ______________________

Phone Number: (____) ______________________ Fax Number: (____) ______________________

Address: ______________________ City: ______________________ State: ________ Zip: ____________

Signature: ______________________ Date: ____________ E-Mail Address: ______________________

Agent/Broker Name: ______________________ Aetna Agent Number/Tax ID/SSN: ______________________

Agency Name: ______________________ % of Credit: ______________________

Phone Number: (____) ______________________ Fax Number: (____) ______________________

Address: ______________________ City: ______________________ State: ________ Zip: ____________

Signature: ______________________ Date: ____________ E-Mail Address: ______________________

General Agent Name: ______________________ Aetna Agent Number/ID Number: ______________________

Phone Number: (____) ______________________ Fax Number: (____) ______________________

Address: ______________________ City: ______________________ State: ________ Zip: ____________

Signature: ______________________ Date: ____________ E-Mail Address: ______________________

Section V: SIGNATURE

It is understood that, except as provided under applicable regulations, no individual shall become insured while not actively at work on a full time basis, and only full-time employees are eligible. A full-time employee is one who regularly works at least 25 hours per week at his employer's place of business.

It is further understood that no agent has power on behalf of Aetna Health Inc. and Aetna Life Insurance Company to make or modify any request or application for insurance or to bind Aetna Health Inc. and Aetna Life Insurance Company by making any promise or representation or by giving or receiving any information.

It is further understood that no insurance will be effective unless and until the application is accepted in writing by Aetna Health Inc. and Aetna Life Insurance Company. Final rates will be based on enrollment data as of the Policy effective date. No contract of insurance is to be implied in any way on the basis of the completion and/or submission of this application.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Date at ______________________ on ______________________

Print Name of Officer, Partner or Proprietor ______________________

Signature of Officer, Partner or Proprietor ______________________

Witness to Signature ______________________

Note: If there are any modifications to the statements and answers given in this application (i.e., crossed out, whited-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.

EMPLOYER CERTIFICATION

Legal Name and Address of Company	Group Policy Number or Group Number (if a current customer)

(For Existing Small Employer Groups in the State of New Jersey OR New Applicants)

An Eligible Employee is one who works on a full-time basis with a normal work week of 25 or more hours for compensation. An employee who works less than 25 hours per week on a temporary or substitute basis, or an employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement is not an eligible employee.

Total # Eligible Employees __________

Total # Eligible Employees applying/enrolling for health benefits coverage __________

Total # Employees waiving health benefits coverage under the policy with coverage under their spouse's coverage, other than individual coverage, or any other Health Benefits Plan offered by the employer. __________

Total # Eligible employees waiving health benefits coverage under the policy without coverage under a spouse's coverage, other than individual coverage; or any other Health Benefits Plan offered by the employer. __________

Total # Employees in an ineligible class or classes __________

Is your firm subject to Working Aged Provisions of federal law (TEFRA/DEFRA)? ☐ Yes ☐ No
(You *may* be subject to the law if you employed 20 or more employees for 20 weeks in the current or prior calendar year)

Is your firm subject to the requirements of the federal COBRA law? ☐ Yes ☐ No
(You *may* be subject to the law if you employed 20 or more employees during 50% or more of the working days during the previous calendar year.)

CERTIFICATION AS A SMALL EMPLOYER IN THE STATE OF NEW JERSEY IN ACCORDANCE WITH NEW JERSEY STATUTE, CHAPTER 27A OF TITLE 17B

For a policy of Group Health Benefits Insurance

(Please sign and date appropriate section indicating whether or not you meet the definition of a small employer)

"Small Employer" means, in connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that:

- employed an average of at least two, but not more than 50, eligible Employees on business days during the preceding Calendar Year, and
- employs at least two Employees on the first day of the Plan Year, and
- the majority of the Employees are employed in New Jersey.

All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an employer that was not in existence during the preceding Calendar Year, the determination of whether the employer is a small or large employer shall be based on the average number of Employees that it is expected that the employer will employ on business days in the current Calendar Year.

☐ **I certify that I qualify as a Small Employer in the State of New Jersey.**

AND

☐ **I certify that the information provided to Aetna is true and complete.** I understand that if the above information is not complete or is not provided to Aetna in a timely manner, then health benefits coverage does not have to be offered or continued. I further understand that incomplete or untrue information may void health benefits coverage.

I understand that I and my employees may be subject to fines if an employee who is a resident of New Jersey and is eligible for coverage under this group health benefits plan is enrolled in an individual health benefits plan issued on or after August 1, 1993.

Signature of Officer, Partner or Owner   Title   Date

Print Name of Officer, Partner or Owner

Signature of Witness   Date

☐ **I certify that I am NOT a Small Employer in the State of New Jersey as defined above.**

Signature of Officer, Partner or Owner   Title   Date

Print Name of Officer, Partner or Owner

Signature of Witness   Date

Any person who includes any false or misleading information on an application or enrollment form or certification for a health benefits plan is subject to criminal and civil penalties.

*EMPLOYEE CENSUS INFORMATION

Please include the following persons in the following list:

a employees, owners, partners, officers, and independent contractors who are actively working for the employer on a regular basis, and are paid by the employer on a regular basis, whether or not they are eligible to be covered under the policy.

b employees, owners, partners, officers, and independent contractors who are not working, but who are currently covered under the employer's health benefits plan for reasons such as continuation of coverage or total disability.

Please use the following letters to indicate Status:

F: Full-time employee who works 25 or more hours per week
P: Part-time employee who works less than 25 hours per week
T: Temporary employee
I: Independent Contractor
D: Totally Disabled employee
C: Continuee under state or federal law
U: Employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement.

Work Location (State)	Name	Job Title	Date of Employment	Hours worked per	Status	Gender	Date of Birth
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							

*If additional space is needed, attach a separate sheet.

New Jersey Small Group Enrollment/Change Request
Aetna Health Inc.
Aetna Life Insurance Company

Employer Group Information - To Be Completed by Employer

Group Name			
Medical - 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	Reason
☐ Add Spouse	/ /	
☐ Add Dependent Child	/ /	
☐ Name Change	/ /	
☐ Change Plan	/ /	
☐ Other	/ /	

☐ Add/Change Office ID Numbers: Primary / Dentist

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

	Effective Date	Reason
☐ Remove Spouse*	/ /	
☐ 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*

Date of Loss of Coverage: ___/___/___

Date of Qualifying Event: ___/___/___

*Attach proof of total disability.

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			Work Telephone ( )
Work Address		City, State	ZIP Code
Date of Employment		Hours Worked Per Week	

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

1. Medical - Check One:

☐ NJ HMO:
☐ Plan 1 ☐ Plan 2 ☐ Plan 3 ☐ Plan 4

☐ NJ HMO No-Referral:
☐ Plan 1 ☐ Plan 2 ☐ Plan 3 ☐ Plan 4

☐ NJ Cost-Sharing HMO:
☐ Plan 1 ☐ Plan 2 ☐ Plan 3

☐ NJ POS No-Referral:
☐ Plan 1 ☐ Plan 2 ☐ Plan 3
☐ Plan 4 ☐ Plan 5 ☐ Plan 6

☐ Out-of-Region PPO Plan:
☐ $250 (High) ☐ $500 (Medium) ☐ $1000 (Low)

☐ State Mandated Plans:
- NJ HMO:
☐ $5 Plan ☐ $10 Plan ☐ $15 Plan
☐ $20 Plan ☐ $30 Plan
- NJ Indemnity:
☐ Plan A1 ☐ Plan A2 ☐ Plan B
☐ Plan C ☐ Plan D ☐ Plan E1
☐ Plan E2

☐ Other Plan ______________

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

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

E. Pre-Existing Conditions Statement

NOTE: This information may **ONLY** be used to determine if a condition is a pre-existing condition. You **CANNOT** be denied coverage under a health benefits plan on the basis of accurate responses to the following questions. Carriers can only use the information to expedite the processing of claims.

Yes No
☐ ☐ 1. During the past 6 months, have you or any dependent to be covered had or been diagnosed as having any of the following? If "Yes," check appropriate box(es) below.

- ☐ a. Alcoholism or Drug Abuse
- ☐ b. Arthritis
- ☐ c. Blood Disorder
- ☐ d. Back or Neck Disorder, Injury or Pain
- ☐ e. Cancer or Tumors
- ☐ f. Diabetes
- ☐ g. Gastro or Intestinal Disorder
- ☐ h. Heart Disorder or Condition or Chest Pain
- ☐ i. High Blood Pressure
- ☐ j. Kidney or Liver Disorder
- ☐ k. Lung or Respiratory Disorder
- ☐ l. Mental or Nervous Disorder
- ☐ m. Paralysis, Stroke or Epilepsy

Yes No
2. During the past 6 months, have you or any dependent to be covered:
- ☐ ☐ a. been examined or treated by a physician or other health care provider for any condition, illness, or injury, other than as stated above?
- ☐ ☐ b. been advised to have treatment or surgery or testing that has not been done?
- ☐ ☐ c. been admitted to a hospital or other health care facility as an inpatient?
- ☐ ☐ d. taken prescribed medications?

Please give details for "Yes" answers to any part of Questions 1 or 2 on a separate sheet of paper. This separate sheet should be signed and dated.

F. Other/Previous Insurance

Is your Spouse Employed? ☐ Yes ☐ No If "Yes," give name & address of spouse's employer.

If "Yes" to **Other Health Coverage** (Section D), give name & policy number 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 **Other Rx Drug Coverage** (Section D), give name & policy number of insurance carrier, HMO, or other source.

If "Yes" to **Previous Coverage**, identify name(s) of persons, give effective date and date coverage terminated, name of previous carrier and plan number.

G. Dependent Information

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

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

H. 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 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 the employee copy of this Enrollment/Change Request Form. I authorize deductions from my earnings for any required contributions.

Employee Signature - *Required*	E-Mail Address	Date
X		/ /

I. Employer Verification - To Be Completed by Employer

Employer Signature - *Required*	Title	Date
X		/ /

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. and/or Aetna Life Insurance Company prior to visiting a specialist or admission to a hospital.

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** 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 Form 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.

Section C - Plan Option:

- Check one Plan Option box for Medical coverage(s) (where applicable).
- Select only an option offered by your employer.

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.
- If a dependent is a full-time college student, you **must** attach a current course schedule or a letter from the school confirming full-time student status (12 or more credits). If a 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 **F** - 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.
- If you are a current patient, please check the "Current Patient" box.

Section E - Pre-Existing Conditions Statement:

Complete this section for all new enrollments. **Exceptions** for Small Employer Group coverage, this section must be completed only by persons enrolling for coverage in a group of 2 - 5 employees, and by late entrants.

Section F - 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 G - Dependent Information:

Complete this section for all new enrollments or coverage changes.

Section H - 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 I - 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.

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 Health 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.
   b) I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which Aetna Health 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 Health 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 Health 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.

SMALL EMPLOYER (2-50)
PROOF OF ELIGIBILITY FORM

For Sole Proprietors, Partners, or Corporate Officers

(To be used for eligible employees enrolling that are not reported on a quarterly wage and tax form)

Please Print:

Full Name (First, MI, Last)	Phone No. ( )
Title	Percentage of Ownership in Firm %
Company Name	
Address	
City / State / ZIP Code	

Please check one of the following: **Small Employer Requirements for Proof of Eligibility:**
(Anyone enrolling must appear on the following documents)

☐ **SOLE PROPRIETOR** .... Submit one of the following documents:
Latest Filed Schedule C. A Business License, ***or***
Fictitious Business Name Filing may be accepted if Schedule C not filed yet filed.

☐ **PARTNER** .... Submit one of the following documents:
Latest Filed Schedule K ***or*** Partnership Agreement may be accepted if Schedule K not filed yet.

☐ **CORPORATE OFFICER** .... Submit one of the following documents:
Statement by Domestic Stock Corporation ***or*** Articles of Incorporation may be accepted if all officers are listed ***and a***
Certification of Qualification (if incorporated in a different state)

I attest that while I am not listed on the state's quarterly wage and tax form for this company, all of the following are true:

1. I am a sole proprietor, partner, or corporate officer of the company indicated above; and
2. I am actively at work at this company on a full time, permanent basis; and
3. I draw wages, dividends, or other distributions from this company on a regular basis and
4. I have satisfied the designated waiting period before health insurance coverage is to become effective.

I understand this information may be subject to audit and agree to provide Aetna US Healthcare® (Aetna), and/or it's affiliates, with any and all information and documentation necessary to validate the above statements. I also understand that any misrepresentation by me of my true circumstances may result in the termination of group health coverage from Aetna, and/or its affiliates, for myself, my enrolled dependents, and/or this company as Aetna, and/or its affiliates, may choose. Aetna, and/or its affiliates, also expressly reserves any other rights and remedies.

Employee
Signature: X____ **Date:** ____________________

AETNA LIFE INSURANCE COMPANY

NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS WAIVER OF COVERAGE

Group Policy No. ______________

Policyholder Name: ____

Employee Name: ______________________________ Social Security # _____________
Last First MI

Marital Status: Single Married Widowed Divorced

Date of Employment: ___________________ Date of Birth _____________________

I was given the opportunity to enroll in this plan of group health benefits offered by my employer and insured by Aetna Life Insurance Company. I refuse the following:

Employee, Spouse and Child(ren) coverage

Spouse coverage

Child(ren) coverage

Reason for Refusal (Please check all appropriate boxes.)

other group coverage sponsored by my employer

other group coverage sponsored by my spouse's employer

other group coverage by another organization

other reasons (please explain) ____

Please provide name of carrier and policy number: ________________________________

I understand that if I later wish to enroll for any of the coverage(s) refused, I will be required to submit an Enrollment Form and Health Statement, and coverage may be subject to a preexisting conditions exclusion.

_______________________________________ __________________________
Signature of Employee Date

_______________________________________ __________________________
Signature of Witness Date

FORM - NJWAIVER - 1/94