aetna℠

# HINT Supplemental Enrollment Information Form Implementing P.L. 2005, c.375

**Aetna Health Inc.*** underwrites for HMO and HNO products and the in-network component of the POS product. **Aetna Health Insurance Company** underwrites the out-of-network component of the POS product. **Aetna Life Insurance Company** underwrites all other products.

*For Small Group Employers (2-50 lives), **Aetna Health Inc.** underwrites all HMO, HNO, and POS products.

## A. Group & Employee Information

| Group Name | Group Number/Control Number |
|---|---|
| Employee Name | Aetna Member ID Number |

## B. Type of Activity (see Important Explanatory Information below)

**Change** - *Check all that apply.*

Effective Date of Coverage (date the coverage is to be effective)

_____/_____/_____ ☐ Add young adult dependent over the limiting age, but less than 31

_____/_____/_____ ☐ Remove young adult dependent over the limiting age, but less than 31

Reason(s): _____

_____

NOTE: all effective dates of coverage are subject to Aetna's standard policies and procedures.

**Billing Method** (Aetna will bill the young adult dependent directly. The young adult dependent will remit the premium directly to Aetna.)

☒ Direct Bill young adult dependent (add billing address, *required* even if the same as the employee address):

Street, Apt. Number: _____

City, State, ZIP Code: _____

## C. Young Adult Dependent Information

| Name (Last, First, MI) | Sex ☐ M ☐ F | Birthdate (MM/DD/YYYY) / / | Social Security Number |
|---|---|---|---|
| | | | |

Other Health Coverage: ☐ Yes ☐ No

Other Rx Drug Coverage: ☐ Yes ☐ No

Primary Office ID Number: _____

Ob/Gyn Office ID Number: _____

Current Patient: ☐ Yes ☐ No

Current Patient: ☐ Yes ☐ No ☐ N/A

Previous Coverage: ☐ Yes ☐ No If yes, provide the following information AND submit a copy of the Certificate of Creditable Coverage that was issued by the previous carrier, if available:

Effective date of prior coverage: _____/_____/_____

Termination date of prior coverage: _____/_____/_____

Name of prior carrier: _____

Prior plan number: _____

## D. Signature

I have read the important information below and agree to the conditions of enrollment. The information supplied in this application is true and complete to the best of my knowledge and belief.

| **Employee** | Date |
|---|---|
| **Young Adult Dependent** | Date |

### IMPORTANT EXPLANATORY INFORMATION

The employee must continue coverage in order for the young adult dependent to be covered. In addition, the young adult must meet the applicable eligibility criteria below. The young adult dependent will be enrolled in their own plan.

A young adult may request to continue or newly enroll as an over-age dependent on his or her parent's coverage even after the child reaches the limiting age under the terms of the policy if the adult child:

- is not yet 31 years old;
- is unmarried;
- has no children;
- lives in New Jersey or, if not a New Jersey resident, is a full-time student at an accredited institution of higher education;
- is not eligible for Medicare and is not actually covered under another group or individual health plan.

A young adult may make the request to continue or newly enroll as an over-age dependent on his or her parent's coverage either:

- when he or she has reaches the limiting age,
- when he or she first becomes eligible for a reason other than reaching the limiting age (for example, the adult child becomes a full-time student in another state, or returns to live in New Jersey after residing elsewhere), or
- anytime the dependent meets the above eligibility requirements.