



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	Employee's Aetna 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 <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate (MM/DD/YYYY) / /	Dependent's Aetna ID Number
Other Health Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No	Other Rx Drug Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Primary Office ID Number: _____	Ob/Gyn Office ID Number: _____		
Current Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
Previous Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> 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. Signatures

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.