Medical: Aetna Medical Enrollment/Change Form

West Windsor Plainsboro Regional School District

Instructions: You, the employee, must complete this enrollment form in full or it will be returned to you resulting in a delay of processing. You are solely responsible for its accuracy and completeness. Complete each section.

Employee Information

Full Name: ______________________________ **Date of Birth:** ____________
Last *First* *M.I.* MM/DD/YYYY

Street Address: ______________________________

City, State Zip Code: ______________________________

Phone: ____________ **Email:** ____________ **SSN:** ____________ **Gender:** ____

Enrollment or Change

Enrollment into New Coverage	Change to Existing Coverage	Effective Date: / /
☐ New Hire Enrollment	☐ Change Existing Coverage	☐ Other
☐ Life Event: Date / /	☐ Add Spouse/ Partner	☐ Remove Spouse/Partner
☐ Open Enrollment	☐ Add Child Dependent	☐ Remove Child Dependent

Medical Plan Options: Choose one coverage type and one coverage level

Coverage Type		Coverage Level
☐ Choice POS II 10	☐ Select (HMO) 10	☐ Single
☐ Choice POS II 15	☐ Select (HMO) 15/25	☐ Parent & Child/Children
☐ Choice POS II 15/25	☐ Select (HMO) 20	☐ Employee/Spouse/Partner
☐ Choice POS II 20	☐ Select (HMO) 20/35	☐ Family
☐ Choice POS II 20/35	☐ High Deductible 1500	

Spouse or Child Dependent Information: If Applicable

Last Name, First Name M.I.	Sex (M/F)	Birth Date MM/DD/YYYY	Relation	Social Security Number	HMO Plan Only PCP #

Disclaimer and Signature

I acknowledge by enrolling in an Aetna plan, coverage is provided by Aetna in accordance with the contract. Enrollment of myself and of the listed dependents into the plan is effective on acceptance by Aetna. 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. 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 form. I authorize deductions from my earnings for any required contributions. www.aetna.com

Signature: ______________________________ Date: ____________

HR Use ONLY **Employee Start Date ____/____/______ Plan Effective Date ____/____/_______**