GSHP Medical & RX: Aetna 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

Plan		Coverage Level
☐ **GSHP**		☐ **Single**
		☐ **Parent & Child/Children**
		☐ **Employee/Spouse/Partner**
		☐ **Family**

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

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** ____/____/_____