aetna®

Life Enrollment/Change Request

Aetna Life Insurance Company

A. Transaction Information

1. Enrollment
- ☐ New Employee ☐ Retiree
- ☐ Rehire/Reinstatement

Effective Date (MM/DD/YYYY) _____

Date of Hire (MM/DD/YYYY) _____

Requested Employee Coverage
- ☐ Basic Life
- ☐ AD&PL/AD&D
- ☐ Supplemental Life
- ☐ Supplemental AD&PL/AD&D

Requested Dependent Coverage
- ☐ Basic Dependent Life
- ☐ Basic Dependent AD&PL/AD&D
- ☐ Supplemental Dependent Life
- ☐ Supplemental Dependent AD&PL/AD&D

2. Termination (Cancel)
- ☐ Employee *

* Employee must be enrolled for dependent(s) to have coverage.

Effective Date (MM/DD/YYYY) _____

3. Change (*Provide explanation in Section D, Special Remarks.)
- ☐ Add Dependent(s) ☐ Plan Change
- ☐ Remove Dependent(s) ☐ Other*
- ☐ Increase/Decrease Benefit Amount*

Effective Date (MM/DD/YYYY) _____

B. Employer Information

1. Employer Name - Full Name of Business or Organization	2. Control No.	Suffix	Account	3. Plan Number	4. SFO
LOCAL 262 OF N.J. RWDSU/UFCW	287511				

5. Employer Address (Street, City, State, ZIP Code) - Primary Location of Business or Organization	6. Claim Office Code	7. Customer Code (Optional)
711 FAIRFIELD AVE. KENILWORTH N.J. 07033		

C. Employee Information - Please Print all Information

1. Employee Social Security Number	2. Employee Name (Last, First, M.I.)	3. Birthdate (MM/DD/YYYY)	4. Sex	5. Telephone Numbers
- -		/ /		Home ( ) - Work ( ) -

6. Employee Home Address (Number, Street, Apt. No., City, State, ZIP Code)	7. Employee Annual Earnings	8. Occupation/Title
	$	

9. Employee Coverage Amounts (Based on the requirements of your Plan, you may have to submit evidence of good health.)

Basic Life Amount	Supplemental Life Amount	Basic AD&PL/AD&D Amount	Supplemental AD&PL/AD&D Amount
$	$	$	$

10. Beneficiary Designation - If more than one beneficiary, use Special Remarks. Dependent coverage Beneficiary is always the Employee.

Full Beneficiary Name (First, Middle, Last)	Social Security Number of Beneficiary	Relationship to Employee
	- -	

D. Covered Dependents (Complete only if Dependent Coverage is offered under your Plan.)

☐ Check this box if you are refusing coverage for your dependents.

(A)dd/New (C)hange (R)emove	Dependent Name (First, Middle Initial, Last)	Social Security Number (If dependent has no SSN, write "None")	Relation. Code	Birthdate MM / DD / YYYY	Student Age 19 or Older Yes No	Basic Dependent Amount	Supplemental Dependent Amount	Basic Dependent AD&PL/AD&D Amount	Supplemental Dependent AD&PL/AD&D Amount
		- -		/ /	☐ ☐	$	$	$	$
		- -		/ /	☐ ☐	$	$	$	$
		- -		/ /	☐ ☐	$	$	$	$
		- -		/ /	☐ ☐	$	$	$	$

Special Remarks

E. Certification - Signatures Required

Employee's E-mail Address:

My signature below signifies my agreement with the statements and authorization under **Certification and Authorization** on the back of this form.

1. Employee Signatures *(Required)*	Date	2. Employer Signature *(Required)*	Date
X		X	