AmeriHealth New Jersey
Application for Small Group Member Coverage

APPLY

AmeriHealth New Jersey
259 Prospect Plains Rd, Building M
Cranbury, NJ 08512

AmeriHealth New Jersey	Group Information – to be completed by Employer:		
AmeriHealth New Jersey	Group Name:	Group Number:	Class Code:

A. Type of Activity – To be completed by Applicant. *Refer to instructions before completing this form. Print clearly.*

	Activity – Check all that apply	Date of Event	Date of Hire/Reason for Change
ADD	☐ Enrollment of a new Subscriber	___/___/___	Date:___/___/___ Reason:_____
	☐ Add Spouse	___/___/___	Date:___/___/___ Reason:_____
	☐ Add Civil Union Partner	___/___/___	Date:___/___/___ Reason:_____
	☐ Add Domestic Partner	___/___/___	Date:___/___/___ Reason:_____
	☐ Add Dependent Child	___/___/___	Date:___/___/___ Reason:_____
	☐ Add Over-Age Child as a Dependent Under 31 *(and complete Coverage Continuation section)*	___/___/___	Date:___/___/___ Reason:_____
REMOVE	☐ Employee Withdrawal/Termination	___/___/___	Date:___/___/___ Reason:_____
	☐ Remove Spouse	___/___/___	Date:___/___/___ Reason:_____
	☐ Civil Union Partner	___/___/___	Date:___/___/___ Reason:_____
	☐ Remove Domestic Partner	___/___/___	Date:___/___/___ Reason:_____
	☐ Remove Dependent Child	___/___/___	Date:___/___/___ Reason:_____
	☐ Remove Over-Age Child as a Dependent Under 31	___/___/___	Date:___/___/___ Reason:_____
OTHER CHANGES	☐ Name Change	___/___/___	_____
	☐ Change Plan	___/___/___	_____
	☐ Other	___/___/___	_____
	☐ Add/Change Office ID Numbers: Primary/OB/Gyn/Dentist	___/___/___	_____
	** See list of Triggering Events in Instructions*		

COVERAGE CONTINUATION	☐ For Employee	☐ Total Disability* ☐ COBRA/NJSGC	Length of Continuation (in months): ☐ 18 ☐ 29	Date of Loss of Coverage: ___/___/___	Qualifying Event #: _____**	Date of Qualifying Event: ___/___/___
	Billing: ☐ Group ☐ Home (Section B)					***Attach proof of disability**
	☐ For Spouse/Civil Union Partner*	Length of Continuation (in months): ☐ 18 ☐ 36	Date of Loss of Coverage: ___/___/___	Qualifying Event #: _____**	Date of Qualifying Event: ___/___/___	
	Billing: ☐ Group ☐ Home (what address?) ☐ Section B OR ☐ Section E			***Civil union partners are eligible to make an election pursuant to NJSGC, if applicable.**		
	☐ For Dependent/ Over-age Child	☐ COBRA/NJSGC	Length of Continuation (in months): ☐ 18 ☐ 36	Date of Loss of Coverage: ___/___/___	Qualifying Event #: _____**	Date of Qualifying Event: ___/___/___
	☐ Dependent Under 31	Qualifying Event #: _____**	Billing: ☐ Group ☐ Home (what address?) ☐ Section B OR ☐ Section E			
	****Qualifying event #s: see list in Instructions. ***Billing through the group for a Dependent Under 31 Continuation Election requires agreement by the employer at Section J.**					

B. Employee Information – To be completed by the Employee

Name (Last, First, MI):	SSN:	Birthdate (mm/dd/yyyy)	Sex: ☐ M ☐ F

HOME	Street/Apt:_____ Street/Apt:_____ City, State, Zip Code:_____ Phone:_____ Email:_____
WORK	[Employer] Name:_____ Address:_____ City, State, Zip Code:_____ Phone:_____ Email:_____ Employment Date:_____ Hours worked per week:_____

ACTIVITY	☐ Add ☐ Remove ☐ Continuation ☐ Other Change – *If a name change, indicate prior name:*		
	Primary Loc #:	NPI or PCP ID #:	Current Patient: ☐ Yes ☐ No
	Address:		
	Ob/Gyn Loc #:	NPI or PCP ID #:	Current Patient: ☐ Yes ☐ No
	Address:		
	Dentist Loc #:	NPI or PCP ID #:	Current Patient: ☐ Yes ☐ No
	Address:		

Other Health Coverage? ☐ Yes ☐ No If yes: Payer Name: _____ Policy #: _____ Medicare ID#, if any: _____	Other Rx Coverage? ☐ Yes ☐ No If yes: Payer Name: _____ Policy #: _____ Medicare ID#, if any: _____

C. Plan Option – to be completed by the Employee | Plan Name:

D. Other Individuals Covered – to be completed by the Employee *Identify individuals other than yourself for whom you are adding/changing removing coverage. Attach additional pages if necessary, dated and signed by you. Attach proof of disability if necessary.*

1.Spouse/Domestic Partner/ Civil Union Partner	2. Child	3. Child	4. Child
☐ Add ☐ Remove ☐ Other ☐ Continue Spouse ☐ Continue CU Partner (NJSGC)	☐ Add ☐ Remove ☐ Other ☐ Continue	☐ Add ☐ Remove ☐ Other ☐ Continue	☐ Add ☐ Remove ☐ Other ☐ Continue
Name (last, first, MI) L:_____ F:_____ MI:	Name (last, first, MI) L:_____ F:_____ MI:	Name (last, first, MI) L:_____ F:_____ MI:	Name (last, first, MI) L:_____ F:_____ MI:
Birthdate (mm/dd/yyyy):___/___/___	Birthdate (mm/dd/yyyy):___/___/___	Birthdate (mm/dd/yyyy):___/___/___	Birthdate (mm/dd/yyyy):___/___/___
☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Social Security Number:	Social Security Number:	Social Security Number:	Social Security Number:
Other health coverage ☐ No ☐ Yes – If Yes: Payer Name: _____ Policy #: _____ Medicare ID #: _____	Other health coverage ☐ No ☐ Yes – If Yes: Payer Name: _____ Policy #: _____ Medicare ID #: _____	Other health coverage ☐ No ☐ Yes – If Yes: Payer Name: _____ Policy #: _____ Medicare ID #: _____	Other health coverage ☐ No ☐ Yes – If Yes: Payer Name: _____ Policy #: _____ Medicare ID #: _____
Other Rx Coverage: ☐ No ☐ Yes – If Yes: Payer Name: _____ Policy #: _____ Medicare ID #: _____	Other Rx Coverage: ☐ No ☐ Yes – If Yes: Payer Name: _____ Policy #: _____ Medicare ID #: _____	Other Rx Coverage: ☐ No ☐ Yes – If Yes: Payer Name: _____ Policy #: _____ Medicare ID #: _____	Other Rx Coverage: ☐ No ☐ Yes – If Yes: Payer Name: _____ Policy #: _____ Medicare ID #: _____
Primary Care Provider: NPI or PCP ID #: _____ Address: _____ _____ _____ Current Patient? ☐ Yes ☐ No ☐ NA	Primary Care Provider: NPI or PCP ID #: _____ Address: _____ _____ _____ Current Patient? ☐ Yes ☐ No ☐ NA	Primary Care Provider: NPI or PCP ID #: _____ Address: _____ _____ _____ Current Patient? ☐ Yes ☐ No ☐ NA	Primary Care Provider: NPI or PCP ID #: _____ Address: _____ _____ _____ Current Patient? ☐ Yes ☐ No ☐ NA
Ob/Gyn Office NPI or PCP ID #: _____ Address: _____ _____ _____ Current Patient? ☐ Yes ☐ No ☐ NA	Ob/Gyn Office NPI or PCP ID #: _____ Address: _____ _____ _____ Current Patient? ☐ Yes ☐ No ☐ NA	Ob/Gyn Office NPI or PCP ID #: _____ Address: _____ _____ _____ Current Patient? ☐ Yes ☐ No ☐ NA	Ob/Gyn Office NPI or PCP ID #: _____ Address: _____ _____ _____ Current Patient? ☐ Yes ☐ No ☐ NA

Dentist Office NPI or PCP ID #: _____ Address: _____ _____ _____ Current Patient? ☐ Yes ☐ No ☐ NA	Dentist Office NPI or PCP ID #: _____ Address: _____ _____ _____ Current Patient? ☐ Yes ☐ No ☐ NA	Dentist Office NPI or PCP ID #: _____ Address: _____ _____ _____ Current Patient? ☐ Yes ☐ No ☐ NA	Dentist Office NPI or PCP ID #: _____ Address: _____ _____ _____ Current Patient? ☐ Yes ☐ No ☐ NA
Employed? ☐ Yes ☐ No *If yes, complete Section E1*	If last name is different from Employee's, please explain: _____ _____	If last name is different from Employee's, please explain: _____ _____	If last name is different from Employee's, please explain: _____ _____
Home or billing address same as Employee? ☐ Yes ☐ No *If NO, complete Section E2*	Living with Employee? ☐ Yes ☐ No *If NO, complete Section F*	Living with Employee? ☐ Yes ☐ No *If NO, complete Section F*	Living with Employee? ☐ Yes ☐ No *If NO, complete Section F*

E. Additional Spouse/Civil Union Partner/Domestic Partner Information – to be completed by Employee If *not applicable, please mark as "NA."*

1.	Employer Name:_____ Employer Address:_____ City, State, Zip Code:_____ Phone:_____
2.a	Street/Apt:_____ Street/Apt:_____ City, State, Zip Code:_____
2.b	Please explain why the address is different:_____ _____ _____

F. Additional Child Information – to be completed by Employee *Provide information below about children listed in Section D, if they have a different address from the employee. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.*

Name(s):_____ Street/Apt:_____ Street/Apt:_____ City, State, Zip Code:_____ Reason:_____	Name(s):_____ Street/Apt:_____ Street/Apt:_____ City, State, Zip Code:_____ Reason:_____

G. Race/Ethnicity – to be completed by Employee at his/her option. *NOTE: your response is appreciated but NOT required!*

Choose a category that most closely describes you:
☐ American Indian or Alaskan Native ☐ Black, not of Hispanic origin ☐ Hispanic ☐ Asian or Pacific Islander ☐ White, not of Hispanic origin

H. Employee Signature

I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I authorize deductions from my earnings for any contributions required from me.

Signature:	Date:____/____/____

I. Over-Age Child's Signature

I represent that all the information supplied in this application regarding the Dependent Under 31 Continuation Election is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I hereby agree to make contributions required from me for the Dependent Under 31 Continuation Election.

Signature:	Date:____/____/____

J. Employer Verification

The requested activity is believed eligible and is approved by the Employer. In addition, the Employer consents to payroll deduction for Dependent Under 31 Continuation Election: ☐ Yes ☐ No

Employer Representative:	Date:____/____/____
Representative's Title:	

INSTRUCTIONS

Employers – You must complete the Employer Group Information and sections A and J in order for this application to be processed.

Employees – You must complete sections B through H and submit the signature of each Over-Age Child for which a Dependent Under 31 Continuation Election is made in accordance with Section I in order for this application to be processed.

- Please PRINT except when a signature is requestedprovide further requested information.
- If a dependent is disabled and you want to continue his or her coverage beyond age 26, you do not have to make a COBRA/NJSGC or Dependent Under 31 election. Instead, select "Other" in Section A3, and attach proof of disability.If a dependent child is disabled and you want to continue his or her coverage beyond age 26, describe this in "Other Change" in Section A, and attach proof of disability.
- For provider addresses, include the zip code plus the four digit extension (9 digits)
- You can obtain the providers' correct names and addresses from the appropriate provider directory. You may also obtain each provider's NPI or PCP ID number from www.amerihealth.com. Providers with multiple office locations and individual providers who belong to more than one practice or provider entity may have more than one NPI or PCP ID number. You should confirm the correct NPI or PCP ID number for the specific provider and office location where you will be seen by contacting that office directly.

Triggering Events

COBRA and NJSGC

C1. Termination of job or reduction in hours
C2. Employee enrollment in Medicare (COBRA only)
C3. Divorce (COBRA/NJSGC); civil union dissolution (NJSGC)
C4. Death of employee
C5. Loss of dependent child status under the plan
C6. Disability (occurring subsequent to another qualifying event)

Dependent Under 31

D1. Loss of dependent status and otherwise eligible
D2. Reestablish eligibility: residency
D3. Reestablish eligibility: nonresident full-time student
D4. Reestablish eligibility: change in marital status
D5. Reestablish eligibility: change in parental status
D6. Reestablish eligibility: termination of other coverage

CONDITIONS OF ENROLLMENT – APPLICANT ACKNOWLEDGEMENTS AND AGREEMENTS

On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer reporting agency, and any employer to give AmeriHealth New Jersey, or any consumer reporting agency acting on behalf of AmeriHealth New Jersey, information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that AmeriHealth New Jersey has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one.
4. I agree AmeriHealth New Jersey will provide coverage in accordance with the terms of the contract for the individual plan.
5. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the individual plan if premiums are not paid timely.

MISREPRESENTATIONS

Any person who includes any false or misleading information on a Nongroup Enrollment/Change Request Form for a health benefits plan is subject to criminal and civil penalties.

IMPORTANT: The Patient Protection and Affordable Care Act (PPACA) requires that you have pediatric dental coverage. To help you meet that requirement we have pre-selected our Smile for Health Family C40A50 dental plan which provides coverage for you and any eligible family members including pediatric dental coverage as required by PPACA. If you do not select the Smile for Health Family C40A50 dental plan, you will need to provide proof of coverage in another Pediatric Dental plan to ensure that you meet the Federal requirements under PPACA.

AmeriHealth NEW JERSEY

AmeriHealth Insurance Company of New Jersey | AmeriHealth HMO, Inc.
Febuary 2014 — Small Group Member / Enrollment Change Request 17972

AmeriHealth NEW JERSEY

Health insurance that pays.SM

Health Benefits Waiver of Coverage

AmeriHealth New Jersey
259 Prospect Plains Rd, Building M
Cranbury, NJ 08512

GROUP NAME	
GROUP POLICY #	
EMPLOYEE NAME (Last, First, MI):	
SOCIAL SECURITY #	
DATE OF BIRTH	____/____/____
DATE OF HIRE	____/____/____
MARITAL STATUS	☐ Single ☐ Married ☐ Widowed ☐ Divorced

I was given the opportunity to enroll in this plan of group health benefits offered by my employer and insured by AmeriHealth New Jersey.

I REFUSE the following:

- ☐ Employee, Spouse and Child(ren) Coverage
- ☐ Spouse Coverage
- ☐ Child(ren) Coverage

Reasons for Refusal (Please indicate all that apply.)

- ☐ other group coverage sponsored by my employer
- ☐ other group coverage sponsored by my spouse's employer
- ☐ other group coverage sponsored by another organization
- ☐ other reasons - please explain: _____

Please provide name of carrier and policy number: _____

I understand that if I later wish to enroll for any of the coverage(s) refused, I will be required to submit an Enrollment Form.

Signature of Employee:

Date: ____/____/____

Signature of Witness:

Date: ____/____/____