Fax to Princeton HR: 866-625-6856

AmeriHealth NEW JERSEY

Individual Coverage Application

Please mail to:
AmeriHealth New Jersey
259 Prospect Plains Road, Building M
Cranbury, NJ 08512
Tel 609-662-2400

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	Reason
Add	☐ Enrollment of a new Subscriber ☐ Add Spouse ☐ Add Civil Union Partner ☐ Add Domestic Partner ☐ Add Dependent Child		
Remove	☐ Remove Subsriber ☐ Remove Spouse ☐ Remove Civil Union Partner ☐ Remove Domestic Partner ☐ Remove Dependent Child		
Other Changes	☐ Name Change ☐ Change Plan ☐ Special Enrollment Period (due to a Triggering Event*) ☐ Other ☐ Add/Change Office ID Numbers: Primary/OB/Gyn/Dentist		
	*See list of Triggering Events in instructions. Provide evidence of triggering event with the enrollment form		

B. Applicant Information

Name (Last, First, MI)	SSN	Birthdate (mm/dd/yyyy)
Email		
By providing an email address you consent to receive information, including the policy, by electronic means.		

☐ Male ☑ Female	Are you a resident of New Jersey? ☐ Yes ☐ No	Do you maintain a home in any other state or country? ☐ Yes ☐ No ***If yes to the above***, name of state/country Number of months you live there each year

Address Information	**Primary Residence**		
	Street/Apt		
	Street/Apt	City	
	State	Zip Code	Phone
	Other Residence		
	Street/Apt		
	Street/Apt	City	
	State	Zip Code	Phone
	Your billing address: ☐ Primary residence ☐ Other residence ☐ P.O. Box or Other *(specify)* Mailing address (for communications other than bills: ☑ Primary residence ☐ Other residence ☐ P.O. Box or Other (specify)		
Activity	☐ Add ☐ Remove ☐ Other Change ☑ Continue *If a name change, indicate prior name:*		
	Primary Loc #	NPI or PCP ID #	
	Address	Zip +4	Current Patient? ☐ Yes ☐ No
	Ob/Gyn Loc #	NPI or PCP ID #	
	Address	Zip +4	Current Patient? ☐ Yes ☐ No
	Dentist Loc #	NPI or PCP ID #	
	Address	Zip +4	Current Patient? ☐ Yes ☐ No

Are you eligible for Medicare? ☐ Yes ☐ No
Are you covered under Medicare Parts A or B? ☐ Yes ☐ No
Please note: If you are eligible for Medicare, the individual policy will coordinate as secondary payor to what Medicare paid or would have paid. Individual policies do not operate as Medicare supplement policies.

Are you covered under any health coverage? ☐ Yes ☐ No
If yes, why are you applying for individual coverage?

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C. Medical Plan Options:

Select Plan	
Catastrophic Portfolio	
☐	Local Value Simple Saver
Bronze Portfolio	
☐	EPO HSA AmeriHealth Advantage $25/$50
☐	EPO HSA AmeriHealth Hospital Advantage $50/$75
☐	EPO HSA Local Value 50%/50%
☐	EPO Local Value $50/$75
Silver Portfolio	
☐	SELECT EPO AmeriHealth Advantage $25/$60
☐	SELECT EPO HSA AmeriHealth Hospital Advantage $50/$75
☐	SELECT HMO Local Value $50/$75
☐	EPO AmeriHealth Advantage $25/$60
☐	EPO HSA AmeriHealth Hospital Advantage $50/$75
☐	HMO Local Value $50/$75
☐	HMO Regional Preferred $50/$75
☐	EPO HSA Local Value $50/$75
☐	EPO Regional Preferred $50/$75
Gold Portfolio	
☐	HMO Regional Preferred $20/$50
☐	EPO Regional Preferred $30/$50

AmeriHealth New Jersey Ancillary Plans

Pediatric Dental Options

Required: ☐ IHC Pediatric Dental ☐ IHC Pediatric Dental with Adult Preventative ☐ Attest to having pediatric dental coverage elsewhere

IMPORTANT: The Patient Protection and Affordable Care Act (PPACA) requires that you have pediatric dental coverage. To help you meet that requirement, AmeriHealth New Jersey has pre-selected our two Pediatric Dental plan options which provide coverage for you and any eligible family members including pediatric dental coverage as required by PPACA. If you do not select either the IHC Pediatric Dental, or IHC Pediatric Dental with Adult Preventative dental plans, you must attest to having pediatric dental coverage elsewhere.

Adult Vision Options

☐ Adult Vision Care $100/ $150 ☐ Adult Vision Care $130/ $180 ☐ Adult Vision Care $150/ $200

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D. Other Individuals Covered – *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.*

1.Spouse/Domestic Partner/ Civil Union Partner	2. Child	3. Child	4. Child
☐ Add ☐ Remove ☐ Other	☐ Add ☐ Remove ☐ Other	☐ Add ☐ Remove ☐ Other	☐ Add ☐ Remove ☐ Other
Name (last, first, MI)	**Name (last, first, MI)**	**Name (last, first, MI)**	**Name (last, first, MI)**
Last	Last	Last	Last
First	First	First	First
MI	MI	MI	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
SSN	SSN	SSN	SSN
Eligible for Medicare? ☐ Yes ☐ No Covered under Medicare Parts A or B? ☐ Yes ☐ No Covered under any health coverage? ☐ Yes ☐ No	Eligible for Medicare? ☐ Yes ☐ No Covered under Medicare Parts A or B? ☐ Yes ☐ No Covered under any health coverage? ☐ Yes ☐ No	Eligible for Medicare? ☐ Yes ☐ No Covered under Medicare Parts A or B? ☐ Yes ☐ No Covered under any health coverage? ☐ Yes ☐ No	Eligible for Medicare? ☐ Yes ☐ No Covered under Medicare Parts A or B? ☐ Yes ☐ No Covered under any health coverage? ☐ Yes ☐ No
Primary Care Provider NPI or PCP ID #	**Primary Care Provider** NPI or PCP ID #	**Primary Care Provider** NPI or PCP ID #	**Primary Care Provider** NPI or PCP ID #
Address _____ _____ Zip+4 _____	Address _____ _____ Zip+4 _____	Address _____ _____ Zip+4 _____	Address _____ _____ Zip+4 _____
Current Patient? ☐ Yes ☐ No	Current Patient? ☐ Yes ☐ No	Current Patient? ☐ Yes ☐ No	Current Patient? ☐ Yes ☐ No
Ob/Gyn Office NPI or PCP ID #	**Ob/Gyn Office** NPI or PCP ID #	**Ob/Gyn Office** NPI or PCP ID #	**Ob/Gyn Office** NPI or PCP ID #
Address _____ _____ Zip+4 _____	Address _____ _____ Zip+4 _____	Address _____ _____ Zip+4 _____	Address _____ _____ Zip+4 _____
Current Patient? ☐ Yes ☐ No	Current Patient? ☐ Yes ☐ No	Current Patient? ☐ Yes ☐ No	Current Patient? ☐ Yes ☐ No
Dentist Office NPI or PCP ID #	**Dentist Office** NPI or PCP ID #	**Dentist Office** NPI or PCP ID #	**Dentist Office** NPI or PCP ID #
Address _____ _____ Zip+4 _____	Address _____ _____ Zip+4 _____	Address _____ _____ Zip+4 _____	Address _____ _____ Zip+4 _____
Current Patient? ☐ Yes ☐ No	Current Patient? ☐ Yes ☐ No	Current Patient? ☐ Yes ☐ No	Current Patient? ☐ Yes ☐ No
If last name is different from Applicant, please explain	If last name is different from Applicant, please explain	If last name is different from Applicant, please explain	If last name is different from Applicant, please explain
Home address same as Applicant? ☐ Yes ☐ No *If NO, complete Section E*	Home address same as Applicant? ☐ Yes ☐ No *If NO, complete Section E*	Home address same as Applicant? ☐ Yes ☐ No *If NO, complete Section E*	Home address same as Applicant? ☐ Yes ☐ No *If NO, complete Section E*

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

Street/Apt			b. Please explain why the address is different
Street/Apt			
City	State	Zip Code	

F. Additional Child Information – *Provide information below about children listed in Section D, if they have a different address. 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	Phone
Reason		
Name(s)		
Street/Apt		
Street/Apt	City	
State	Zip Code	Phone
Reason		

G. Race / Ethnicity – *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. Payment Information – *Indicate how you would like to be billed and make payment.*

☐ Bill me monthly ☐ Check

I. Applicant's 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.

Signature	Date

J. Broker/General Agent Signature

Signature of Preparer Lisa Keith	Date	☐ NJ Producer License # ☐ NPN 7547222
General Agent		Agent ID #

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