

## OTHER ITEMS REQUIRED WITH SUBMISSION OF POLICY

### WR30

ATTACH A COPY OF YOUR WR30 (WAGE & PAYROLL) FOR THE LATEST QUARTER OR APPROPRIATE TAX DOCUMENTATION

- ✓ OXFORD REQUIRES NO WR30
- ✓ AETNA REQUIRES WR30 FOR LESS THAN 5 ENROLLING, BUT IT IS A 6 EE ELIGIBLE GROUP
- ✓ ALL OTHER CARRIERS REQUIRE WR30 2-5 ELIGIBLE. IN OTHER WORDS IF THE GROUP HAS 6 ELIGIBLE EMPLOYEES, BUT ONLY 3 ENROLLING, WR30 IS NOT NECESSARY UNLESS UNDERWRITING COMES BACK AND MAKES A REQUEST TO SEE IT.

### CARRIER BILL

A COPY OF YOUR LAST BILLING STATEMENT SHOWING ALL THE EMPLOYEES ENROLLED FROM YOUR PREVIOUS CARRIER

### PREMIUM CHECK

ALL NEW CASES MUST SUBMIT A CHECK MADE OUT TO THE CARRIER WITH THE ESTIMATED MONTHLY PREMIUM AMOUNT FROM THE QUOTE. THIS MUST BE A COMPANY BUSINESS CHECK

### QUOTE

ATTACH A COPY OF THE QUOTED ESTIMATED PREMIUM. PLEASE CIRCLE THIS PLAN DESIGN AND AMOUNT AND HAVE THE CLIENT SIGN THEIR NAME ANYWHERE WITHIN THE PLAN DESCRIPTION OR BY THE RATES. THIS IS AN ACKNOWLEDGEMENT OF PLAN DESIGN/RATES QUOTED.

### TERMINATION OF PRIOR CARRIER

DON'T FORGET TO SEND A LETTER OFF TO THE PRIOR CARRIER, CANCELLING THE COVERAGE. PLEASE DO NOT DO SO UNTIL YOU RECEIVE APPROVAL ON THE COVERAGE THAT YOU ARE APPLYING FOR. PLEASE NOTE THAT ALL CARRIERS REQUIRE YOU TO CANCEL PRIOR OR 30 DAYS BEFORE YOUR EFFECTIVE DATE OF YOUR RENEWAL. OTHERWISE, THEY HAVE THE RIGHT TO BILL YOU. SO, YOU MAY WANT TO PUSH OUT YOUR NEW COVERAGE EFFECTIVE DATE. PLEASE CONSULT YOUR BROKER TO CHECK ON TIMEFRAMES.



**SECTION II: SPECIFICATIONS FOR COVERAGE**

**HMO**

Copayment:  \$15  \$20  \$30  \$40  
Coinsurance:  \$20/70%  \$30/60%  
Plan:  Basic  Premium  
Standard Drug:  50%/50%  
Select Drug:  \$5/\$25/\$50  \$10/\$40/\$60  \$15/\$35/\$50  
 \$7/\$35/\$50  \$15/\$25/\$35  \$20/\$40/\$60  
Deductible /Copayment Drug:  \$100/\$15/\$15  \$100/\$15/\$25  
 \$200/\$15/\$15  \$200/\$15/\$25  
 \$100/\$15/\$25/\$35  \$200/\$15/\$25/\$35

Drug Retail Dispensing/Copays: 90 Day/3 Copays  
(For Deductible /Copayment Program, Deductible must be met first)

**Split Copay HMO**

\$15/\$30 \$0/Day  \$15/\$30 \$200/Day  \$20/\$40 \$0/Day  
 \$20/\$40 \$300/Day  \$30/\$50 \$0/Day  \$30/\$50 \$400/Day

**HMO Plus**

\$15/\$30 \$200/Day  \$20/\$40 \$300/Day  \$30/\$50 \$400/Day

Standard Drug:  50%/50%  
Select Drug:  \$5/\$25/\$50  \$10/\$40/\$60  \$15/\$35/\$50  
 \$7/\$35/\$50  \$15/\$25/\$35  \$20/\$40/\$60

Drug Retail Dispensing/Copays: 90 Day/3 Copays

Vision:  \$35  \$100

**PPO**      **Deductible**      **Copay**  
 Plan B  \$500  \$1,000  \$2,500       \$30  
(80/60) Combined Deductible in/out-of-network  
 Plan C  \$250  \$500  1,000  \$2,500       \$20       \$30  
(100/70) Out-of-network Deductible  
 Plan D  \$250  \$500  \$1,000       \$20  
(100/80) Out-of-network Deductible

100% Hospitalization      Integrated Drug  
 Yes  Yes  
 No  No

Standard Drug:  50%/50%  
Select Drug:  \$5/\$25/\$50\*  \$10/\$40/\$60 \*  \$15/\$35/\$50\*  
 \$7/\$35/\$50\*  \$15/\$25/\$35  \$20/\$40/\$60\*

Deductible/Copayment Drug:  \$100/\$15/\$15\*  \$100/\$15/\$25\*  
 \$200/\$15/\$15\*  \$200/\$15/\$25\*  
 \$100/\$15/\$25/\$35\*  \$200/\$15/\$25/\$35\*

\* Only available with Plan B and Plan C medical options with an office visit copay of \$20 or more and an Out-of-Network deductible of \$500 or more

Drug Retail Dispensing/Copays: 90 Day/3 Copays  
(Except Integrated Drug: For Ded/Copay Program, Deductible must be met first)

Vision:  \$35  \$100

**POS**

Copayment:  \$15  \$20  \$30  \$40  
Plan:  Basic  Premium  
Option:  1  2  3  4  5  6  7  
Standard Drug:  50%/50%  
Select Drug:  \$5/\$25/\$50  \$10/\$40/\$60  \$15/\$35/\$50  
 \$7/\$35/\$50  \$15/\$25/\$35  \$20/\$40/\$60  
Deductible /Copayment Drug:  \$100/\$15/\$15  \$100/\$15/\$25  
 \$200/\$15/\$15  \$200/\$15/\$25  
 \$100/\$15/\$25/\$35  \$200/\$15/\$25/\$35

Drug Retail Dispensing/Copays: 90 Day/3 Copays  
(For Deductible /Copayment Program, Deductible must be met first)

**Split Copay POS**

\$15/\$30 \$0/Day  \$15/\$30 \$200/Day  \$20/\$40 \$0/Day  
 \$20/\$40 \$300/Day  \$30/\$50 \$0/Day  \$30/\$50 \$400/Day

**POS Plus**

\$15/\$30 \$200/Day  \$20/\$40 \$300/Day  \$30/\$50 \$400/Day

Standard Drug:  50%/50%  
Select Drug:  \$5/\$25/\$50  \$10/\$40/\$60  \$15/\$35/\$50  
 \$7/\$35/\$50  \$15/\$25/\$35  \$20/\$40/\$60

Drug Retail Dispensing/Copays: 90 Day/3 Copays

Vision:  \$35  \$100

**Traditional Med (CMM)**

Plan:  A  B  C  D  E

Deductible:  \$150 (Plans A & E)  
 \$250 (Plans B,C or D)  
 \$500 (Plans B,C or D)  
 \$1,000 (Plans B,C or D)

Integrated Drug (Not available with A)  
 Yes  No

Standard Drug:  \$5/\$10(\$0/\$5 mail)

Drug Retail Dispensing/Copays: 90 Day/3 Copays  
(Except Integrated Drug)

**SECTION III: ALL QUESTIONS MUST BE ANSWERED**

1. Is there any Group Health plan:

- now in force and to be continued?  Yes  No
- currently being applied for?  Yes  No

If "Yes," identify the name of the Group Health Plan(s), give a description of the plan(s) and name of insurance carrier(s):

\_\_\_\_\_

2. Name of present or prior group carrier: \_\_\_\_\_

Effective date of prior coverage: \_\_\_\_\_

Cancellation/Termination date: \_\_\_\_\_

Is the coverage applied for in this application replacing other group insurance? [ ] Yes [ ] No

If "Yes," give reason: \_\_\_\_\_

Plan being replaced: [ ] A [ ] B [ ] C [ ] D [ ] E [ ] HMO [ ] HMO-POS [ ] Dual Contract POS

[ ] Other \_\_\_\_\_

3. Has your firm been uninsured for 3 or more months prior to application? [ ] Yes [ ] No

4. What forms of insurance are now or were in force?

[ ] Health Benefits      [ ] Prescription Drugs

(Attach copies of Booklet/Certificate and most recent Billing Statement)



5. Are extended benefits provided in case of termination of health benefits?  Yes  No
6. To the best of your knowledge, are there any current or former employees or their eligible dependents whose health insurance is being continued?  Yes  No

Please provide the following information for each current/former employee or dependent on health continuations.

Name of Employee/Dependent	Date of Birth	Type of Continuation State/Federal Extended Benefits	Reason for Termination Disability/Other	Continuation Dates	
				Start	End

If additional space is needed, attach a separate sheet, signed and dated.

7. To the best of your knowledge:

7a. Are any employees or dependents presently incapacitated?  Yes  No

7b. Are any dependent children incapable of self-support due to a physical or mental disability?  Yes  No

Additional space to explain if Items 1, 2 or 3 were answered "Yes". Refer to the question number, and give details including names, where appropriate.

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**SECTION IV: AGENT/PRODUCER INFORMATION**

\_\_\_\_\_  
Agent/Broker

**SECTION V: SIGNATURE**

It is understood that, except as provided under applicable regulations, no individual shall become insured while not actively at work on a full-time basis, and only full-time employees are eligible. A full-time employee is one who regularly works at least 25 hours per week at his employer's place of business. It is further understood that no agent has power on behalf of AmeriHealth HMO, Inc. and AmeriHealth Insurance Company of New Jersey to make or modify any request or application for insurance or to bind AmeriHealth HMO, Inc. and AmeriHealth Insurance Company of New Jersey by making any promise or representation or by giving or receiving any information.

It is further understood that no insurance will be effective unless and until the application is accepted in writing by AmeriHealth HMO, Inc. and/or AmeriHealth Insurance Company of New Jersey. Final rates will be based on enrollment data as of the policy effective date. No contract of insurance is to be implied in any way on the basis of the completion and/or submission of this application.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Dated at \_\_\_\_\_ on \_\_\_\_\_

\_\_\_\_\_  
Print Name of Officer, Partner or Proprietor

\_\_\_\_\_  
Signature of Officer, Partner or Proprietor

\_\_\_\_\_  
Witness to Signature

Note: If there are any modifications to the statements and answers given in this application (i.e. crossed out, whited-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.





**AmeriHealth**  
**NEW JERSEY**

AmeriHealth HMO, Inc. • AmeriHealth Insurance Company of New Jersey

## NEW JERSEY SMALL EMPLOYER CERTIFICATION

For a policy of Group Health Benefits Insurance

EMPLOYER NAME: \_\_\_\_\_ GROUP POLICY#: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
Street City State Zip

### EMPLOYEE CENSUS INFORMATION

Please include the following persons in the following list:

- a) employees, owners, partners, officers, and independent contractors who are actively working for the employer on a regular basis, whether or not they are eligible to be covered under the policy;
- b) employees, owners, partners, officers, and independent contractors who are not working, but who are currently covered under the employer's health benefits plan for reasons such as continuation of coverage or total disability.

**Please use the following letters to Indicate Status:**

- F: Full-time employee who works 25 or more hours per week
- I: Independent Contractor
- P: Part-time employees who work less than 25 hours per week
- D: Total Disabled employee
- T: Temporary employee
- C: Continuee under state or federal law
- U: Employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement

	Name	Job Title	Date of Employment	Hours Worked per Week	Status	Work Location (State)
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						

If additional space is needed, attached a separate sheet.

**CERTIFICATION AS A SMALL EMPLOYER IN THE STATE OF NEW JERSEY IN ACCORDANCE WITH NEW JERSEY CH. 162**

Group Health Benefits Policy Participation (All Questions Must Be Answered)

An Eligible Employee is one who works on a full-time basis with a normal work week of 25 or more hours for pay. An employee who works less than 25 hours per week or on a temporary or substitute basis, or an employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement, is not an eligible employee.

Total # of Eligible Employees	
Total # of Eligible Employees applying/enrolling for health benefits coverage.	
Total # of Eligible Employees waiving health benefits coverage under this policy with coverage under a spouse's coverage, other than individual coverage or any other Health Benefits Plan offered by the employer.	
Total # of Eligible Employees waiving health benefits coverage under this policy without coverage under a spouse's coverage, other than individual coverage or any other Health Benefits Plan offered by the employer.	
Total # of Eligible Employees in an ineligible class or classes.	

**CERTIFICATION:** (Please sign and date appropriate section including whether or not you meet the definition of a small employer)

A Small Employer means, in connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that employed an average of at least two but not more than 50 eligible Employees on business days during the preceding Calendar Year and who employs at least two Employees on the first day of the Plan Year, and the majority of the Employees are employed in New Jersey. All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an employer that was not in existence during the preceding Calendar Year, the determination of whether the employer is a small or large employer shall be based on the average number of Employees that it is expected that the employer will employ on business days in the current Calendar Year.

**I certify that I qualify as a Small Employer in the State of New Jersey.**

**I certify that the information provided to AmeriHealth HMO, Inc. and AmeriHealth Insurance Company of New Jersey is true and complete. I understand that if the above information is not complete or is not provided to AmeriHealth HMO, Inc. and AmeriHealth Insurance Company of New Jersey in a timely manner, then health benefits coverage does not have to be offered or continued. I further understand that incomplete or untrue information may void health benefits coverage.**

**I understand that I and my employees may be subject to fines if an employee who is a resident of New Jersey and is eligible for coverage under this group health benefits plan is enrolled in an individual health benefits plan issued on or after August 1, 1993.**

**Any person who includes any false or misleading information on an application or enrollment form or certification form for a health benefits plan is subject to criminal or civil penalties.**

Signature of Officer, Partner or Owner	Title	Date
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Print Name of Officer, Partner or Owner

Signature of Witness

**I certify that I am not a Small Employer in the State of New Jersey, as defined above.**

Signature of Officer, Partner or Owner	Title	Date
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Print Name of Officer, Partner or Owner

Signature of Witness	Date
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### SMALL EMPLOYER HEALTH BENEFITS WAIVER OF COVERAGE

**GROUP NAME**

**GROUP POLICY NO**

**EMPLOYEE NAME**  Last  First  M.I.

**SOCIAL SECURITY #**

**DATE OF BIRTH**    Month Day Year **DATE OF HIRE**    Month Day Year

**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.

I REFUSE the following:

REASON FOR REFUSAL (Please indicate all that apply.)

- Employee, Spouse and (Child(ren) Coverage
- Spouse Coverage
- Child(ren) Coverage
- 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, and coverage may be subject to a pre-existing conditions exclusions.

\_\_\_\_\_

Signature of Employee

\_\_\_\_\_  
Date

\_\_\_\_\_

Signature of Witness

\_\_\_\_\_  
Date





**COMPLETE THIS SECTION IF APPLYING FOR COVERAGE UNDER THE NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM ONLY.**

Occupation: \_\_\_\_\_ Title: \_\_\_\_\_ Date of Employment: \_\_\_\_\_ Hours Worked Per Week: \_\_\_\_\_ Are you actively at work? Yes \_\_\_\_\_ No \_\_\_\_\_  
If "No", explain: \_\_\_\_\_

If you are declining enrollment for yourself or your dependents (including your spouse) because of other Group Health Plan coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Persons to be covered:  Employee Only  Employee & Child(ren)  Employee & Spouse  Employee, Spouse & Child(ren)

Which coverage have you selected to be primary in the event expenses are incurred as a result of an automobile related injury? \_\_\_\_\_ Auto \_\_\_\_\_ Medical

Are you replacing existing coverage? Yes \_\_\_\_\_ No If "Yes", give the name and policy number of the replaced carrier, the effective and termination dates, and the name(s) of the persons covered by the policy \_\_\_\_\_

Were you, or any dependent(s) to be covered, covered under a prior Group Health Plan? Yes \_\_\_\_\_ No If "Yes", attach the Certificate of Group Health Plan Coverage. Please note that if you do not provide the Certificate of Group Health Plan Coverage, you and any dependents to be covered, may be required to satisfy the preexisting conditions limitation, if applicable.

**DECLARATION AUTHORIZATION AND CONDITIONS OF ACCEPTANCE FOR THE NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM**

I hereby enroll for the group coverage to which I am or may be entitled. I authorize deductions from my pay for my share of the cost, if any.

I represent that to the best of my knowledge and belief, the statements and answers given above are true and complete. I understand that the information shall form the basis upon which I may be included for coverage under the group plan.

I understand that:

- a) the coverage applied for will not take effect unless:
  - after review of this Enrollment Form, AmeriHealth accepts it;
  - the first premium has been paid to AmeriHealth; and
  - I am either actively at work for full pay on a full-time basis on the date coverage is to take effect, or subject to applicable regulations, I qualify under a waiver of the active work requirement

b) no person, except an officer of AmeriHealth has authority to: determine whether certificate/evidence of coverage shall be issued based on this Enrollment Form, waive or modify any of the provisions of the Enrollment Form, or any of the AmeriHealth Requirements; to bind AmeriHealth by any statement or promise pertaining to any certificate/evidence of coverage to be issued on the basis of this Enrollment Form; or accept any information or representation not contained in the written Enrollment Form.

c) Employer is hereby designated my representative for the purpose of receiving contributions and remitting them to AmeriHealth.  
• AmeriHealth does not pay benefits for charges, or provide services or supplies related to a preexisting condition for 180 days, measured from the enrollment date. I understand that a Pre-Existing Condition is an illness or injury which manifests itself in the six months before a person's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date. I also understand that New Jersey Law only permits the application of the preexisting conditions limitation under certain circumstances and that I or my dependents will only be subject to this limitation to the extent permitted by New Jersey Law.

I understand that by signing below when I file a claim, AmeriHealth may pay the health care benefits directly to the provider instead of to me.

I state that I am a resident of New Jersey and I live, reside or work within AmeriHealth's service area. I understand that if I omit or falsify any statement on this enrollment form, AmeriHealth can cancel my coverage as of the original effective date.

Any person who includes any false or misleading information on an application or enrollment form and change form for a health benefits plan is subject to criminal and civil penalties.

**Note:** A person who was covered under Creditable Coverage has a right to request a certificate from the prior plan or issuer to demonstrate that he or she was covered under Creditable Coverage. If necessary, AmeriHealth will assist the person in obtaining a certificate from the prior plan or issuer.

**Conditions of Acceptance**

On behalf of myself and the dependents listed on this Enrollment Form, I agree to or with the following:

1. Employee is applying for coverage for the employee, employee's spouse and any eligible unmarried children under nineteen (19) years of age, unmarried children who are mentally or physically incapacitated and who are chiefly dependent upon the employee or the employee's spouse for support and maintenance or are unmarried children between the ages of nineteen (19) and twenty-three (23) who are enrolled as full-time students at an accredited school.
2. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the Contract.
3. The Contract will determine the rights and responsibilities of members and will govern in the event it conflicts with any benefits comparison, summary or other description of the health benefits plan.
4. As a condition to receiving in-network benefits, employee understands and agrees that with the exception of emergency procedures as defined in the Contract all in-network services, in order to be covered by AmeriHealth, must be performed either by a participating primary care physician or by the participating specialist, hospital or other provider as authorized by prior written referral from the participating primary care physician. Out-of-network benefits are covered, as stated in the contract.
5. Employee agrees to make payment directly to health care providers such copayments as are provided in the employer's health benefits plan.
6. Employee understands that this coverage will remain in effect regardless of the continued availability of a particular primary care physician.
7. Employee acknowledges that AmeriHealth's participating providers, including all participating primary care physicians, are independent contractors and are not agents or employees of AmeriHealth.

**Authorization**

1. I authorize the sources stated below to give to AmeriHealth, or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, advice, treatment or supplies for any physical or mental condition. Authorized sources are: any physician or medical professional; any hospital, clinic or other medical care institution; any carrier; any consumer reporting agency; any employer.
2. I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which AmeriHealth has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
3. I know that I have a right to receive a copy of this authorization if I request one.
4. I agree that a photocopy of this authorization is as valid as the original.

*I understand that if I choose an HMO Product the provision of services to me and my dependents as Members of AmeriHealth is governed by the applicable Group Master Contract, which provides that: 1) except for emergencies, all medical or dental care must be initiated at the primary care office or primary dental office (as appropriate), we have selected; and 2) and my dependents authorize any person or organization providing services to furnish AmeriHealth with medical or dental records or other information concerning such services for purposes of AmeriHealth quality and utilization review. I understand that if I choose a Point of Service Product, I will be subject to applicable deductible, coinsurance and other copayments for all non-referred services, as specified in the contract. I further understand that I can change health plan coverage only at the time my employer and AmeriHealth specify.*

*Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.*



Send to:  
AmeriHealth Enrollment  
P.O. Box 42555  
Philadelphia, PA 19101-2555

**ENROLLMENT/CHANGE FORM**  
For all plans, including New Jersey Small Group  
Employer Benefits Program

**1 Plan (please specify Fast Track or Standard)**

<b>1A</b> Standard Plans (Indicate co-pay amount and deductible)				<b>1B</b> Fast Track (Circle co-pay)			
HMO	POS	PPO	Rx	Vision	Dental	HMO	POS
						\$10	\$20
						\$10	\$20
						\$10	\$20

**2 Subscriber/Member Enrollment or Change - Employee Must Complete in Full**

New Application  Information Change  Change  Dependent Membership  Other Change  Terminate Contract

New Hire Provide your Identification Number below and indicate the change(s) you are making. Complete appropriate section(s) and sign at bottom of form.

Open Enrollment

Life Event Change

Complete all information and sign form.

I.D. # \_\_\_\_\_

Address \_\_\_\_\_

Last Name \_\_\_\_\_

Primary Care Office \_\_\_\_\_

Refire \_\_\_\_\_

Dental/Office \_\_\_\_\_

Delete Dependent \_\_\_\_\_

Conversion \_\_\_\_\_

Full-time to Part-time \_\_\_\_\_

Deceased, date: \_\_\_\_\_

Open Enrollment \_\_\_\_\_

Other: \_\_\_\_\_

**3 Subscriber Information**

NOTE: Please complete this section in its entirety, whether you are a new applicant or are making a change to an existing contract.

Social Security Number \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Sex  M  F Date of Birth month/day/year \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone Number Home: ( ) - - Work: ( ) - -

Employment Status  Active  COBRA  Retiree

Marital Status  Single  Divorced  Married  Separated  Widowed

Previous Health Insurance \_\_\_\_\_

**3B Complete this section for HMO or POS Only**

Primary Care Office Name \_\_\_\_\_ If Current Physician Check This Box

Primary Dental Office Name \_\_\_\_\_ If Current Dentist Check This Box

Primary Care Office Code Number \_\_\_\_\_ Primary Dental Office Code Number \_\_\_\_\_

Date of Hire \_\_\_\_\_ Date Coverage/Change is Effective \_\_\_\_\_

Payroll/Work Location \_\_\_\_\_ Location Name/Phone # \_\_\_\_\_

**4 Dependent Information - Please provide all information for each person to be covered.**

Full Name Last Name	First Name	Middle Initial	Sex	Date of Birth Month/day/year	Social Security Number	Primary Care Office		4B Verifications	
						Name	Number	Overage Student? Please attach verification.	Disabled? Please attach verification.
Spouse			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**5 Other Insurance Information** To be sure that you receive all the benefits to which you are entitled, you must complete the following:

**5A** Is your spouse employed?  Yes  No  
If yes, please give name, address, and phone number of spouse's employer \_\_\_\_\_

**5B** Are you or any of your dependents currently receiving Medicare benefits  
 Yes  No If yes, please give name of recipient \_\_\_\_\_

	PART A	EFFECTIVE DATE	PART B	EFFECTIVE DATE	MEDICARE CLAIM NUMBER
SELF	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		
SPOUSE	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		
CHILD	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		

**5C** When you become effective with our policy, will any persons listed on this enrollment form be covered by any other health insurance policy?  
 Yes  No  
If yes, please give name and policy no. of insurance carrier and type of benefits.  
Ins. Co. Name \_\_\_\_\_  
Policy Number \_\_\_\_\_  
Policy Holder \_\_\_\_\_  
Type of benefits: \_\_\_\_\_  
 Health  Prescription  Dental  Vision

**Who is covered by this policy? List names of those covered.**  
(1) \_\_\_\_\_  
(2) \_\_\_\_\_  
(3) \_\_\_\_\_  
(4) \_\_\_\_\_

Important: Please read the back of this form, then sign below.

Signature of Employee \_\_\_\_\_ Date Signed \_\_\_\_\_

Signature of Employer \_\_\_\_\_ Date Signed \_\_\_\_\_

**COMPLETE THIS SECTION IF APPLYING FOR COVERAGE UNDER THE NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM ONLY.**

Occupation: \_\_\_\_\_ Title: \_\_\_\_\_ Date of Employment: \_\_\_\_\_ Hours Worked Per Week: \_\_\_\_\_ Are you actively at work? Yes \_\_\_ No \_\_\_  
If "No," explain: \_\_\_\_\_

If you are declining enrollment for yourself or your dependents (including your spouse) because of other Group Health Plan coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Persons to be covered:  Employee Only  Employee & Child(ren)  Employee & Spouse  Employee, Spouse & Child(ren)

Which coverage have you selected to be primary in the event expenses are incurred as a result of an automobile related injury? \_\_\_ Auto \_\_\_ Medical

Are you replacing existing coverage? \_\_\_ Yes \_\_\_ No If "Yes", give the name and policy number of the replaced carrier, the effective and termination dates, and the name(s) of the persons covered by the policy \_\_\_\_\_

Were you, or any dependent(s) to be covered, covered under a prior Group Health Plan? \_\_\_ Yes \_\_\_ No If "Yes", attach the Certificate of Group Health Plan Coverage. Please note that if you do not provide the Certificate of Group Health Plan Coverage, you and any dependents to be covered, may be required to satisfy the preexisting conditions limitation, if applicable.

**DECLARATION AUTHORIZATION AND CONDITIONS OF ACCEPTANCE FOR THE NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM**

I hereby enroll for the group coverage to which I am or may be entitled. I authorize deductions from my pay for my share of the cost, if any.

I represent that to the best of my knowledge and belief, the statements and answers given above are true and complete. I understand that the information shall form the basis upon which I may be included for coverage under the group plan.

I understand that:

- a) the coverage applied for will not take effect unless:
  - after review of this Enrollment Form, AmeriHealth accepts it;
  - the first premium has been paid to AmeriHealth; and
  - I am either actively at work for full pay on a full-time basis on the date coverage is to take effect, or subject to applicable regulations, I qualify under a waiver of the active work requirement
- b) no person, except an officer of AmeriHealth has authority to: determine whether certificate/evidence of coverage shall be issued based on this Enrollment Form, waive or modify any of the provisions of the Enrollment Form, or any of the AmeriHealth Requirements; to bind AmeriHealth by any statement or promise pertaining to any certificate/evidence of coverage to be issued on the basis of this Enrollment Form; or accept any information or representation not contained in the written Enrollment Form.
- c) The Employer is hereby designated my representative for the purpose of receiving contributions and remitting them to AmeriHealth.
  - AmeriHealth does not pay benefits for charges, or provide services or supplies related to a preexisting condition for 180 days, measured from the enrollment date. I understand that a Pre-Existing Condition is an illness or injury which manifests itself in the six months before a person's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date. I also understand that New Jersey Law only permits the application of the preexisting conditions limitation under certain circumstances and that I or my dependents will only be subject to this limitation to the extent permitted by New Jersey Law.

I understand that by signing below when I file a claim, AmeriHealth may pay the health care benefits directly to the provider instead of to me.

I state that I am a resident of New Jersey and I live, reside or work within AmeriHealth's service area. I understand that if I omit or falsify any statement on this enrollment form, AmeriHealth can cancel my coverage as of the original effective date.

Any person who includes any false or misleading information on an application or enrollment form and change form for a health benefits plan is subject to criminal and civil penalties.

**Note:** A person who was covered under Creditable Coverage has a right to request a certificate from the prior plan or issuer to demonstrate that he or she was covered under Creditable Coverage. If necessary, AmeriHealth will assist the person in obtaining a certificate from the prior plan or issuer.

**Conditions of Acceptance**

On behalf of myself and the dependents listed on this Enrollment Form, I agree to or with the following:

1. Employee is applying for coverage for the employee, employee's spouse and any eligible unmarried children under nineteen (19) years of age, unmarried children who are mentally or physically incapacitated and who are chiefly dependent upon the employee or the employee's spouse for support and maintenance or are unmarried children between the ages of nineteen (19) and twenty-three (23) who are enrolled as full-time students at an accredited school.
2. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the Contract.
3. The Contract will determine the rights and responsibilities of members and will govern in the event it conflicts with any benefits comparison, summary or other description of the health benefits plan.
4. As a condition to receiving in-network benefits, employee understands and agrees that with the exception of emergency procedures as defined in the Contract all in-network services, in order to be covered by AmeriHealth, must be performed either by a participating primary care physician or by the participating specialist, hospital or other provider as authorized by prior written referral from the participating primary care physician. Out-of-network benefits are covered, as stated in the contract.
5. Employee agrees to make payment directly to health care providers such copayments as are provided in the employer's health benefits plan.
6. Employer understands that this coverage will remain in effect regardless of the continued availability of a particular primary care physician.
7. Employee acknowledges that AmeriHealth's participating providers, including all participating primary care physicians, are independent contractors and are not agents or employees of AmeriHealth.

**Authorization**

1. I authorize the sources stated below to give to AmeriHealth, or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, advice, treatment or supplies for any physical or mental condition. Authorized sources are: any physician or medical professional; any hospital, clinic or other medical care institution; any carrier; any consumer reporting agency; any employer.
2. I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which AmeriHealth has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
3. I know that I have a right to receive a copy of this authorization if I request one.
4. I agree that a photocopy of this authorization is as valid as the original.

*I understand that if I choose an HMO Product the provision of services to me and my dependents as Members of AmeriHealth is governed by the applicable Group Master Contract, which provides that: 1) except for emergencies, all medical or dental care must be initiated at the primary care office or primary dental office (as appropriate) we have selected; and 2) and my dependents authorize any person or organization providing services to furnish AmeriHealth with medical or dental records or other information concerning such services for purposes of AmeriHealth quality and utilization review. I understand that if I choose a Point of Service Product, I will be subject to applicable deductible, coinsurance and other copayments for all non-referred services, as specified in the contract. I further understand that I can change health plan coverage only at the time my employer and AmeriHealth specify.*

*Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any material false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.*



Send to:  
AmeriHealth Enrollment  
P.O. Box 42555  
Philadelphia, PA 19101-2555

**ENROLLMENT/CHANGE FORM**  
For all plans, including New Jersey Small Group  
Employer Benefits Program

**1 Plan (please specify Fast Track or Standard)**

<b>1A</b> Standard Plans (Indicate co-pay amount and deductible)						<b>1B</b> Fast Track (Circle co-pay)				
HMO	POS	PPO	CMM	Rx	Vision	Dental	HMO	POS	PPO	
							\$10	\$20	\$10	\$20

**2 Subscriber/Member Enrollment or Change - Employee Must Complete in Full**

**New Application**  **Information Change**  **Change**  **Dependent Membership Change**  **Other Change**  **Terminate Contract**

New Hire Provide your Identification Number below and indicate the change(s) you are making. Complete appropriate section(s) and sign at bottom of form.

Open Enrollment

Life Event Change If adding spouse, indicate marriage date: \_\_\_/\_\_\_/\_\_\_

Add Dependent

Primary Care Office

Rehire

Reire

Dental/Office

Delete Dependent

Conversion

Terminated Employment

Full-time to Part-time

Deceased, date: \_\_\_/\_\_\_/\_\_\_

Open Enrollment

Other: \_\_\_\_\_

**3 Subscriber Information** NOTE: Please complete this section in its entirety, whether you are a new applicant or are making a change to an existing contract.

Social Security Number \_\_\_\_\_ Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Sex  M  F Date of Birth month/day/year \_\_\_/\_\_\_/\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone Number Home: ( ) - - - - - Work: ( ) - - - - -

Employment Status  Active  COBRA  Retiree

Marital Status  Single  Divorced  Married  Separated  Widowed

Previous Health Insurance \_\_\_\_\_

**3B Complete this section for HMO or POS Only**

Primary Care Office Name \_\_\_\_\_ If Current Physician Check This Box  Primary Care Office Code Number \_\_\_\_\_

Primary Dental Office Name \_\_\_\_\_ If Current Dentist Check This Box  Primary Dental Office Code Number \_\_\_\_\_

Account Number \_\_\_\_\_ Group Address \_\_\_\_\_

Group Number \_\_\_\_\_ Group Name (Full Legal Name of Company) \_\_\_\_\_

Employer Signature and Date \_\_\_\_\_

Date of Hire \_\_\_/\_\_\_/\_\_\_ Date Coverage/Change is Effective \_\_\_/\_\_\_/\_\_\_

Payroll/Work Location \_\_\_\_\_ Location Name/Phone # \_\_\_\_\_

**4 Dependent Information - Please provide all information for each person to be covered.**

Full Name Last Name	First Name	Middle Initial	Sex	Date of Birth Month/day/year	Social Security Number	Primary Care Office		Disability? Please attach verification.
						Name	Number	
Spouse			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No
Child			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No
Child			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No
Child			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No

**5 Other Insurance Information** To be sure that you receive all the benefits to which you are entitled, you must complete the following:

**5A** Is your spouse employed?  Yes  No  
If yes, please give name, address, and phone number of spouse's employer \_\_\_\_\_

**5B** Are you or any of your dependents currently receiving Medicare benefits  
 Yes  No If yes, please give name of recipient.

	PART A EFFECTIVE DATE	PART B EFFECTIVE DATE	MEDICARE CLAIM NUMBER
SELF	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
SPOUSE	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
CHILD	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

**5C** When you become effective with our policy, will any persons listed on this enrollment form be covered by any other health insurance policy?  
 Yes  No  
If yes, please give name and policy no. of insurance carrier and type of benefits.  
Ins. Co. Name \_\_\_\_\_  
Policy Number \_\_\_\_\_  
Policy Holder \_\_\_\_\_  
Type of benefits:  Health  Prescription  Dental  Vision

**4A For HMO/POS Only** **4B Verifications** **4C**

If you have listed any dependents in the Dependent Information Section, you must answer the questions below. Do any of the dependents listed in this section live at another address?  
 Yes  No  
If yes, who and at what address? Explain the circumstances: \_\_\_\_\_  
If any dependent's last name is different from yours, explain the circumstances: \_\_\_\_\_

**Who is covered by this policy? List names of those covered.**  
(1) \_\_\_\_\_  
(2) \_\_\_\_\_  
(3) \_\_\_\_\_  
(4) \_\_\_\_\_

Important: Please read the back of this form, then sign below.

**COMPLETE THIS SECTION IF APPLYING FOR COVERAGE UNDER THE NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM ONLY.**

Occupation: \_\_\_\_\_ Title: \_\_\_\_\_ Date of Employment: \_\_\_\_\_ Hours Worked Per Week: \_\_\_\_\_ Are you actively at work? Yes \_\_\_ No \_\_\_  
If "No", explain: \_\_\_\_\_

If you are declining enrollment for yourself or your dependents (including your spouse) because of other Group Health Plan coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Persons to be covered:  Employee Only  Employee & Child(ren)  Employee & Spouse  Employee, Spouse & Child(ren)

Which coverage have you selected to be primary in the event expenses are incurred as a result of an automobile related injury? \_\_\_ Auto \_\_\_ Medical

Are you replacing existing coverage? \_\_\_ Yes \_\_\_ No If "Yes", give the name and policy number of the replaced carrier, the effective and termination dates, and the name(s) of the persons covered by the policy \_\_\_\_\_

Were you, or any dependent(s) to be covered, covered under a prior Group Health Plan? \_\_\_ Yes \_\_\_ No If "Yes", attach the Certificate of Group Health Plan Coverage. Please note that if you do not provide the Certificate of Group Health Plan Coverage, you and any dependents to be covered, may be required to satisfy the preexisting conditions limitation, if applicable.

**DECLARATION AUTHORIZATION AND CONDITIONS OF ACCEPTANCE FOR THE NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM**

I hereby enroll for the group coverage to which I am or may be entitled. I authorize deductions from my pay for my share of the cost, if any.

I represent that to the best of my knowledge and belief, the statements and answers given above are true and complete. I understand that the information shall form the basis upon which I may be included for coverage under the group plan.

I understand that:

a) the coverage applied for will not take effect unless:

- after review of this Enrollment Form, AmeriHealth accepts it;
- the first premium has been paid to AmeriHealth; and
- I am either actively at work for full pay on a full-time basis on the date coverage is to take effect, or subject to applicable regulations, I qualify under a waiver of the active work requirement

b) no person, except an officer of AmeriHealth has authority to: determine whether certificate/evidence of coverage shall be issued based on this Enrollment Form, waive or modify any of the provisions of the Enrollment Form, or any of the AmeriHealth Requirements; to bind AmeriHealth by any statement or promise pertaining to any certificate/evidence of coverage to be issued on the basis of this Enrollment Form; or accept any information or representation not contained in the written Enrollment Form.

c) The Employer is hereby designated my representative for the purpose of receiving contributions and remitting them to AmeriHealth. I understand that a Pre-Existing Condition is an illness or injury which manifests itself in the six months before a person's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date. I also understand that New Jersey Law only permits the application of the preexisting conditions limitation under certain circumstances and that I or my dependents will only be subject to this limitation to the extent permitted by New Jersey Law.

I understand that by signing below when I file a claim, AmeriHealth may pay the health care benefits directly to the provider instead of to me.

I state that I am a resident of New Jersey and I live, reside or work within AmeriHealth's service area. I understand that if I omit or falsify any statement on this enrollment form, AmeriHealth can cancel my coverage as of the original effective date.

Any person who includes any false or misleading information on an application or enrollment form and change form for a health benefits plan is subject to criminal and civil penalties.

**Note:** A person who was covered under Creditable Coverage has a right to request a certificate from the prior plan or issuer to demonstrate that he or she was covered under Creditable Coverage. If necessary, AmeriHealth will assist the person in obtaining a certificate from the prior plan or issuer.

**Conditions of Acceptance**

On behalf of myself and the dependents listed on this Enrollment Form, I agree to or with the following:

1. Employee is applying for coverage for the employee, employee's spouse and any eligible unmarried children under nineteen (19) years of age, unmarried children who are mentally or physically incapacitated and who are chiefly dependent upon the employee or the employee's spouse for support and maintenance or are unmarried children between the ages of nineteen (19) and twenty-three (23) who are enrolled as full-time students at an accredited school.
2. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the Contract.
3. The Contract will determine the rights and responsibilities of members and will govern in the event it conflicts with any benefits comparison, summary or other description of the health benefits plan.
4. As a condition to receiving in-network benefits, employee understands and agrees that with the exception of emergency procedures as defined in the Contract all in-network services, in order to be covered by AmeriHealth, must be performed either by a participating primary care physician or by the participating specialist, hospital or other provider as authorized by prior written referral from the participating primary care physician. Out-of-network benefits are covered, as stated in the contract.
5. Employee agrees to make payment directly to health care providers such copayments as are provided in the employer's health benefits plan.
6. Employer understands that this coverage will remain in effect regardless of the continued availability of a particular primary care physician.
7. Employee acknowledges that AmeriHealth's participating providers, including all participating primary care physicians, are independent contractors and are not agents or employees of AmeriHealth.

**Authorization**

1. I authorize the sources stated below to give to AmeriHealth, or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, advice, treatment or supplies for any physical or mental condition. Authorized sources are: any physician or medical professional; any hospital, clinic or other medical care institution; any carrier; any consumer reporting agency; any employer.
2. I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which AmeriHealth has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
3. I know that I have a right to receive a copy of this authorization if I request one.
4. I agree that a photocopy of this authorization is as valid as the original.

*I understand that if I choose an HMO Product the provision of services to me and my dependents as Members of AmeriHealth is governed by the applicable Group Master Contract, which provides that: 1) except for emergencies, all medical or dental care must be initiated at the primary care office or primary dental office (as appropriate) we have selected; and 2) and my dependents authorize any person or organization providing services to furnish AmeriHealth with medical or dental records or other information concerning such services for purposes of AmeriHealth quality and utilization review. I understand that if I choose a Point of Service Product, I will be subject to applicable deductible, coinsurance and other copayments for all non-referred services, as specified in the contract. I further understand that I can change health plan coverage only at the time my employer and AmeriHealth specify.*  
*Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any material false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.*

## Important Notice

### Regarding the Pre-existing Condition Exclusion in this Coverage

#### About the pre-existing condition exclusion

The coverage in which you are enrolling includes a pre-existing condition exclusion. Under this exclusion, you or your dependents will have no coverage for pre-existing conditions for up to six months, if you are enrolled through a New Jersey group, or 12 months if enrolled through a Delaware group.

A pre-existing condition is an illness or injury which manifests itself in the six months before coverage by AmeriHealth is effective and for which you received, or were advised by a provider to receive, medical care, treatment or took drugs or, advice, care or treatment in the six months before coverage begins.

If you have any questions or comments now or in the future, please call AmeriHealth Member Services.

#### Exceptions to the pre-existing condition exclusion

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Small Employer Health plan provides exceptions and limits to pre-existing condition exclusions.

Your pre-existing condition exclusion period can be reduced if you had coverage prior to enrolling with this health plan. You may receive credit for any comprehensive medical coverage in which you were enrolled, as long as you were covered at some time during the three months prior to the effective date of coverage with AmeriHealth.

To receive credit for prior coverage in which you - or a family member - was enrolled, you must fill out the form provided and attach information, such as a Certification of Coverage to your enrollment form. If you believe you or any family member have prior coverage but you do not have a Certification, speak to your Group Leader. You may obtain a Certification of Coverage and submit this at a later date, or AmeriHealth will accept other information while assisting you to obtain a Certification of Coverage from your prior carrier(s). AmeriHealth is not required to credit you for coverage prior to a significant break in coverage.

- After reviewing your enrollment form and attached materials AmeriHealth will provide you with a notice if you are determined to be subject to a pre-existing condition exclusion.

Maternity benefits are not subject to pre-existing condition exclusion. The term "Maternity Benefits" includes prenatal care.

Newborn children, and children placed for adoption are not subject to pre-existing condition exclusions as long as they are enrolled within 30 days following the date of birth, or placement for adoption. If your child was born or adopted since July 1, 1997 and has been continuously covered (with no break in coverage of more than 63 days), note that on the form provided.



**Pre-Ex Check-Off Form  
IMPORTANT!**

**The coverage in which you are enrolling has a pre-existing condition exclusion.** A notice is provided in this kit which explains the pre-existing condition exclusion. If you did not receive a copy of the notice, or if you have any questions after reviewing this document, please contact your Group Leader or the Insurance Agent assisting your group.

**It is possible the pre-existing condition exclusion does not apply to you. Please read the following and check off which of these describes your situation, and to indicate what documents you are submitting to expedite AmeriHealth's determination of whether you can get a waiver of the pre-existing condition exclusion.**

**You or your family members (spouse or child) have not had any health coverage within the last 3 months.**

If this describes you, please submit your application form to AmeriHealth. You will be subject to a pre-existing condition exclusion.

**You, or any family member (spouse or child), have had health coverage within the last 3 months.** If this describes you, please fill out the appropriate areas below and submit this form and the attachments with your application form to AmeriHealth.

\_\_\_\_\_ I do have a Certificate(s) of Coverage for myself or a family member;

\_\_\_\_\_ I do not have a Certificate(s) of Coverage, so I am submitting:

A letter listing the insurers or HMOs with whom I previously had coverage (it can be more than one) and when the coverage was in effect.

**AND**

A copy of a document that shows I did have prior coverage. (This can be a copy of an ID card, a bill, or any other document on official letterhead which provides evidence of prior coverage.)

**\*\*\*\*RETURN THIS FORM WITH YOUR APPLICATION\*\*\*\***

**I understand AmeriHealth is entitled, by law, to verify, with prior carrier(s), any information regarding prior coverage which I have provided. I will assist AmeriHealth in this regard if asked to do so. Providing false or misleading information for the purpose of obtaining coverage is against the law and could result in criminal or civil penalties.**

*Signature* \_\_\_\_\_ *Date* \_\_\_\_\_





## SEH EMPLOYMENT VERIFICATION FORM FOR SPOUSAL GROUPS

AmeriHealth Insurance Company of New Jersey issues and administers insurance policies as mandated by New Jersey Insurance Reform regulations. Regulations and guidelines regarding eligibility and maintenance of a Small Group Plan can be found in Regulations @ N.J.A.C. 11:21 et seq.

I understand that pursuant to these regulations, no individual shall become insured who is not a bona fide employee working on a full-time, compensated basis. Full-time means working at least 25 hours per week and compensation means the employee is working at the employer's place of business for consideration.

I, \_\_\_\_\_ do hereby certify that:

\_\_\_\_\_ and \_\_\_\_\_ are

EMPLOYEES OF: \_\_\_\_\_ which is located at \_\_\_\_\_, and that the parties above meet the definition of "eligible employee" and "small employer" as stated in the State of New Jersey Regulations @ 11:21 et seq.

If the information I have provided is not accurate, complete and true, or if I omitted any facts or made any material misrepresentations of a fact, I understand that I may be in violation of N.J.S.A. 17B:27A-23 et seq. and 17:33A, New Jersey Fraud Prevention Act, as well as 2C:21-4.3.C, Healthcare Claims Fraud with criminal and civil penalties attached. Furthermore, I understand that if I omit material facts or provide false information my contract can be terminated as of the original effective date.

My signature below signifies that I have read and understand the text above.

\_\_\_\_\_  
PRINT NAME – WIFE

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINT NAME – HUSBAND

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE



**Temporary HINT Supplemental Enrollment Information Form  
Implementing P.L. 2005, c. 375**

**Group & Employee Information**

Group Name: \_\_\_\_\_

Group Number: \_\_\_\_\_

Employee Name: \_\_\_\_\_

Employee ID Number: \_\_\_\_\_

**B. Type of Activity (see Important Explanatory Information below)**

Date of Event Change – Check all that apply

\_\_\_/\_\_\_/\_\_\_  Add dependent over the limiting age, but less than 30

\_\_\_/\_\_\_/\_\_\_  Remove dependent over the limiting age, but less than 30

Reason(s):

\_\_\_/\_\_\_/\_\_\_  Continuation of Coverage pursuant to P.L. 2005, c. 375

Coverage is being effected:

During an Open Enrollment

Within 30 days prior to attainment of limiting age

Within 30 days after eligibility for other reasons

During special 12-month enrollment

Billing:  Direct bill dependent. Please provide the billing address:

\_\_\_\_\_  
Street, Apt. Number:

\_\_\_\_\_  
City, State, ZIP Code:

**C. Over-age Dependent Information**

Name (last, first, MI): \_\_\_\_\_ Sex:  M  F

Birthdate: (MM, DD, YY) \_\_\_/\_\_\_/\_\_\_ SSN: \_\_\_\_\_

Other Health Coverage:  Yes  No Other Rx Drug Coverage:  Yes  No

Primary Ofc ID Number: \_\_\_\_\_ Ob/Gyn Ofc ID Number: \_\_\_\_\_

Current Patient:  Yes  No

Current Patient:  Yes  No  N/A

Previous Coverage:  Yes  No

If yes, provide the following information AND submit a copy of the certificate of Creditable Coverage that was issued by the previous carrier, if available:

Effective date of prior coverage: \_\_/\_\_/\_\_

Termination date of prior coverage: \_\_/\_\_/\_\_

Name of prior carrier: \_\_\_\_\_

Prior plan number: \_\_\_\_\_

**D. Signature**

\_\_\_\_\_  
Employee

\_\_\_\_\_  
Dependent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

**IMPORTANT EXPLANATORY INFORMATION**

An adult child may request to continue as a dependent on his or her parent's coverage even after the child reaches the limiting age under the terms of the policy if the adult child:

- is not yet 30 years old
- is unmarried
- has no children
- lives in New Jersey or, if not a New Jersey resident, is a full-time student at an accredited institution of higher education
- is not eligible for Medicare and is not actually covered under another group or individual health plan.

An adult child may make the request to continue as a dependent on his or her parent's coverage either:

- when he or she first reaches the limiting age
- when he or she first becomes eligible for a reason other than reaching the limiting age (for example, the adult child becomes a full-time student in another state, or returns to live in New Jersey after residing elsewhere), or
- during the open enrollment period for the group of which the parent is a member.

In addition, adult children who reached the limiting age under the parent's coverage prior to May 12, 2006 may make an enrollment request at any time from May 12, 2006 through May 11, 2007.

**The adult child or covered employee may be required to pay up to 102% of the cost of the dependent premium.**



**Verification of Requirements**

The AmeriHealth contract states that a dependent may be covered to age 30 if he or she meets certain criteria:

- The dependent’s parent remains covered by the plan, and
- the employer retains coverage with AmeriHealth, and
- Contributions are made by or on behalf of the dependent.

In order to request continued coverage, AmeriHealth requires a verification form be completed indicating that all of the criteria have been met.

**Payment.** The dependent shall be required to pay up to 102% of the dependent premium. The dependent will be billed directly for this cost. The initial premium payment is required at the time of application for coverage. Ongoing premium payment must be received within 31 days of the due date or, coverage will automatically be terminated.

**Important Note:** Although the parent must continue eligibility under the AmeriHealth plan for coverage of the dependent to continue, coverage for the dependent will be issued as stand-alone coverage. This means that all cost-sharing requirements and limitations will apply to the dependent only, and will not be combined with the parent’s policy. Covered expenses incurred by the dependent will not contribute to family deductibles and out-of-pocket maximums, nor will family incurred expenses contribute to dependent’s deductibles or out-of-pocket maximums.

If the dependent meets the qualifications outlined in this Verification, please complete, sign and return it within 30 days of your receipt along with an enrollment application. A separate application and Verification must be completed for each dependent.

Covered Parent/Subscriber Name: \_\_\_\_\_ Unique Identifier Number: \_\_\_\_\_

Dependent Name : \_\_\_\_\_ Dependent SSN: \_\_\_\_\_

Group Number: \_\_\_\_\_ DOB: \_\_\_\_\_ (mm/dd/yyyy)

I, the dependent listed above: (please check all that apply):

- Am less than age 30
- Am unmarried
- Have no dependent of my own
- Am a resident of the State of New Jersey
- Am not a resident of the State of New Jersey, but am enrolled as a full-time student at an accredited public or private institution of higher education
  - Please provide the name of the school \_\_\_\_\_
  - Please provide the expected date of graduation \_\_\_\_\_ (mm/yyyy)
  - Please provide a copy of the class schedule signed and stamped by the Registrar
- I am not actually provided coverage as a named subscriber, insured, enrollee or covered person under any other group health benefits plan or entitled to benefits under Title XVIII of the Social Security Act, Pub.L. 89-97

By signing below, I confirm that the information I have provided is true, accurate, and current.

Signature of Dependent: \_\_\_\_\_ Date: \_\_\_\_\_

Please return this completed form (via fax or mail) to the following address within 30 days of receipt of the letter.

Fax this form: (856) 802-3111.

Mail this form to: Nicolle Russo, AmeriHealth, 8000 Midlantic Drive, Suite 333, Mt. Laurel, NJ 08054

**NJ Commission Disclosure New Jersey law** (N.J.S.A. 17:22A-41.1)

Requires disclosure of the compensation a licensed agent or broker (producer) receives from your purchase or renewal of health coverage. Compensation may be in the form of a commission, fee(s), or possibly other valuable consideration, or a combination of all three.

Total commission levels per carrier are as follows:

- Aetna-7.5%
- AmeriHealth-7.0%
- Cigna-7%
- Health Net-7%
- Horizon-6.75%
- Oxford-7.5%

**PLEASE NOTE:** The commissions do not directly affect the premium paid for the plan and **no plan can be purchased through another distributor or from the carrier directly with a different commission amount or at a lower cost.** Final commission dollar amounts cannot be determined until enrollment is complete and are subject to change based on the number of members covered each month.

**DISCLOSURE OF A FINANCIAL INTEREST  
IN THE SALE OF HEALTH INSURANCE POLICIES**

New Jersey law (N.J.S.A. 17:22A-41.1) requires disclosure of the compensation a licensed agent or broker (producer) receives from your purchase or renewal of health coverage. Compensation may be in the form of a commission, fee(s), or possibly other valuable consideration, or a combination of all three. The per employee dollar amount(s) or percentage(s) of premium are in the table below. All amounts and/or percentages are additive. If something does not apply, it is marked "None" or "NA". If there is compensation, whether or not in addition to the compensation shown, whose amount cannot be determined, enter "CBD" (cannot be determined) on the appropriate line. Use the "Other" line for all other compensation, whether or not the amount is determinable. Agent/Producer

	AGENT/PRODUCER	
	Percentage %	Amount in Dollars (\$) per employee basis
Commission of Issuing Agent		
Commission of General Agent (GA)		
Consultant Fee		
Brokerage Fee		
Other:		

Please note this is a monthly commission that is earned to the Agent/Broker & GA as premium is paid by the client/purchaser. If you decide to go to the carrier and purchase health insurance directly for small group (2-50 ees), the Agent & General Agency commissions are built into the rates and cannot be removed to alleviate the Agent & GA commission who specialize in guiding/consulting you through the process.

**PRODUCER INFORMATION**

Agent Name: \_\_\_\_\_

General Agent Name: \_\_\_\_\_

**CARRIER INFORMATION**

Insurance Company Name: \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agent/Producer Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client/Purchaser of Insurance