ahhh AmeriHealth
NEW JERSEY

INDIVIDUAL ENROLLMENT
NON-GROUP ELECTION FORM

A To enroll in AmeriHealth 65®, please provide the following information:

Please check which plan you wish to enroll in:

	Monthly Premium
AmeriHealth 65 NJ Value HMO Plan	Monthly Premium
☐ Medical Only (No Rx)	$0.00
☐ Rx	$36.10
AmeriHealth 65 NJ Preferred HMO Plan	Monthly Premium
☐ Medical Only (No Rx)	$35.00
☐ Rx	$70.80
AmeriHealth 65 NJ Plus POS Plan	Monthly Premium
☐ Medical Only (No Rx)	$135.00
☐ Rx	$174.00

LAST Name: FIRST Name: Middle Initial ☐ Mr. ☐ Mrs. ☐ Ms.

Sex: ☐ M ☐ F

Birth Date: MM-DD-YYYY

Social Security Number: *(providing this information is optional)* ☐☐☐-☐☐-☐☐☐☐

Home Phone Number: ☐☐☐-☐☐☐-☐☐☐☐

Permanent Residence Street Address:

City: State: ZIP Code:

Mailing Address (only if different from your Permanent Residence Address):

Street Address: City: State: ☐☐ ZIP Code: ☐☐☐☐☐

Emergency Contact: ______________________________

Phone Number: ☐☐☐-☐☐☐-☐☐☐☐ **Relationship to You**:

E-mail Address:

B Please provide your Medicare insurance information

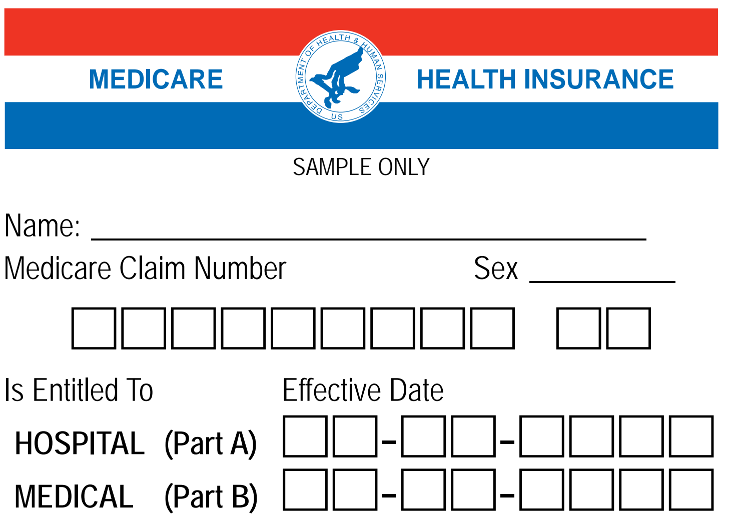
Please take out your Medicare Card to complete this section.

- Please fill in these blanks so they match your red, white, and blue Medicare card

– OR –

- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.



C Paying Your Plan Premium

You can pay your monthly plan premium by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security Check each month.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of the premium, we will bill you for the amount that Medicare does not cover.

If you don't select a payment option, you will receive a bill each month.

Please select a premium payment option:

☐ Receive a bill

☐ Electronic Funds Transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name: ______________________________

Bank routing number: ☐☐☐☐☐☐☐☐☐ Account type: ☐ Checking

Bank account number: ☐☐☐☐☐☐☐☐☐☐☐☐ ☐ Saving

☐ Automatic deduction from your monthly Social Security benefit check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

D Please read and answer these important questions:

1. Do you have End Stage Renal Disease (ESRD)? ☐ Yes ☐ No

If you answered "yes" to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to AmeriHealth 65®? ☐ Yes ☐ No

If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage:	ID # for this coverage:	Group # for this coverage
____________	____________	____________

3. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No

If "yes" please provide the following information:

Name of Institution: ______________________________

Address & Phone Number of Institution (number and street): ______________________________

4. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

If yes, please provide your Medicaid number: ______________________________

5. Do you or your spouse work? ☐ Yes ☐ No

Please contact AmeriHealth 65 at 1-800-898-3492 (TTY users should call toll-free 1-877-219-5457) if you need information in another format (Braille and audio tape) or language. Our office hours are seven days a week, 8 a.m. to 8 p.m.

E Please choose your providers

Primary Care Physician (check box if current physician) ☐	Physician Code No. ☐☐☐☐☐☐☐☐☐☐ The 10-digit number beneath provider name in directory
Primary Dental Office Name	Primary Dental Provider No. ☐☐☐☐☐☐☐☐☐☐ The 10-digit number beneath provider name in directory

F Information to determine enrollment period

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 of each year. In addition, you can join a Medicare Advantage plan during the open enrollment period between January 1 and March 31 of each year, as long as you do not change your prescription drug coverage. Additionally, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare.
- ☐ I recently moved outside of the service area for my current plan.
- ☐ I recently moved and this plan is a new option for me.
- ☐ I have both Medicare and Medicaid or my state helps pay for my Medicare Premiums.
- ☐ I receive extra help paying for Medicare prescription drug coverage.
- ☐ I am no longer eligible for extra help paying for my Medicare prescription drugs.
- ☐ I live in or recently moved out of a Long Term Care Facility (for example, a nursing home or long term care facility).
- ☐ I recently "left" a PACE program.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's).
- ☐ I am either losing coverage I had from an employer or union or leaving employer or union coverage.
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ I recently returned to the United States after living permanently outside of the U.S.
- ☐ None of these statements applies to me.*

***Please contact AmeriHealth 65 at 1-800-898-3492 (TTY users should call toll-free 1-877-219-5457) to see if you are eligible to enroll. We are open seven days a week, 8 a.m. to 8 p.m.**

Please Read This Important Information

If you currently have health coverage from an employer or union, joining AmeriHealth 65® could affect your employer or union health benefits. If you have health coverage from an employer or union, joining AmeriHealth 65 may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

G Please read and sign below

By completing this enrollment application, I agree to the following:

AmeriHealth 65® is a Medicare Advantage plan and has a contract with the federal government. I will need to keep my Parts A and B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I do not have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: November 15 - December 31 of every year), or under certain special circumstances, by sending a request to AmeriHealth 65 or by calling 1-800-MEDICARE. TTY users should call 1-877-486-2048, 24 hours a day/7days a week.

AmeriHealth 65 serves a specific service area. If I move out of the area that AmeriHealth 65 serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of AmeriHealth 65, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from AmeriHealth 65 when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date AmeriHealth 65 coverage begins, I must get all of my health care from AmeriHealth 65, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by AmeriHealth 65 and other services contained in my AmeriHealth 65 Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR AMERIHEALTH 65 WILL PAY FOR THE SERVICES**.

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with AmeriHealth 65 he/she may be compensated based on my enrollment in AmeriHealth 65.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that AmeriHealth 65 will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by AmeriHealth 65 or by Medicare.

Benefits underwritten or administered by AmeriHealth HMO, Inc.

Your Signature:	**Today's Date:** MM-DD-YYYY

If you are the authorized representative, you must sign above and provide the following information:

Name: ______________________

Address: ______________________

Phone Number: ☐☐☐-☐☐☐-☐☐☐☐

Relationship to Enrollee: ______________________

Office Use Only

Name of staff member/agent/broker (if assisted in enrollment): ______________________

Plan ID #: ______________________ Effective Date of Coverage: ______________________

ICEP/IEP: __________ OEP: __________ AEP: __________ SEP (type): __________ Not Eligible: __________