AmeriHealth Insurance Company
AmeriHealth HMO, Inc.
919 N. Market Street, Suite 1200
Wilmington, DE 19801-3021

Group Enrollment Form

Please complete all information requested in its entirety. Any incomplete information will cause delay or rejection of group's enrollment.

Checklist for New Group Submission

For Groups with 1-50 Employees:

- [ ] This completed Group Enrollment Form
- [ ] Enrollment Form for each enrolling employee
- [ ] Completed Pre-ex Form for each enrolling employee
- [ ] Copy of Final Rate Quote Sheet
- [ ] Waivers, as applicable with copy of carrier ID card
- [ ] First month's premium - MUST BE BUSINESS (not personal) CHECK
- [ ] Copy of Prior Carrier Bill
- [ ] UC8 (If UC8 is unavailable, please submit copies of Payroll Records)
- [ ] Permanent Business License
- [ ] Broker of Record Letter, on enrolling company's letterhead and signed by Officer of the Company
- [ ] If you are enrolling 1 through 9 employees, please submit an *Individual Health Questionnaire 1-9* for each enrolling employee

For Groups with 51+ Employees:

- [ ] This completed Group Enrollment Form
- [ ] Enrollment Form for each enrolling employee
- [ ] Copy of Final Rate Quote Sheet
- [ ] Waivers, as applicable with copy of carrier ID card
- [ ] First month's premium - MUST BE BUSINESS (not personal) CHECK
- [ ] Copy of Prior Carrier Bill
- [ ] UC8
- [ ] Permanent Business License
- [ ] Broker of Record Letter, on enrolling company's letterhead and signed by Officer of the Company

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Please Print or Type

1. Group/Employer (full legal name of Company): _____

2. Address: _____
Street City County State Zip

3. Designated Contact: _____ Title: _____ Telephone: (___) _____

4. Type of Organization: [ ] Corporation [ ] Partnership [ ] Other (explain)

5. Today's Date: _____ 6. Requested Effective Date of Coverage: _____

7. Coverage Requested:

Medical: _____ Prescription: _____

Dental: _____ Vision: _____

8. Enrollment :

	Current Enrollment				
	HMO	POS	PPO	CMM	Other
Active Full-Time					
COBRA					
Absentee Owners, Officers/Directors, and Independent Contractors					
Part-Time					
Total					

Please attach copy of Unemployment Compensation Report (UC8) (Eligible employees are those who work at least 30 hours per week)

9. Is this group all-AmeriHealth? [ ] Yes [ ] No 10. Number of employees waiving coverage: _____

11. Payment Amount: _____

12. Nature of Business (specify): _____ SIC Code: _____

13. Insurance Requested For: [ ] Employees Only [ ] Employees and Dependents

14. Waiting period before employees become insured: Present Employees _____ New Employees _____

15. What percentage of the premium will the employer pay? Employee $ ____ or ____% Dependent $ ___or ____%
(50% minimum employer contribution is required)

16. Other health insurers used during the past five years:

Name of Carrier	Coverage		Reason Cancelled
	From	To	

17. Has the health care coverage of the company or any affiliates ever been cancelled by an insurer, or is it in the process of being cancelled by the current carrier? [ ] Yes [ ] No

If Yes, explain: _____

18. Are there any dependent children age 19 or over who might be considered developmentally disabled or physically handicapped? [ ] Yes [ ] No

19. According to the definition below, are you a small employer? [ ] Yes [ ] No

A small employer is any person, firm, corporation, partnership or association actively engaged in business who during at least 50% of its working days in the preceding CALENDAR YEAR QUARTER, employed NO MORE THAN 50 eligible employees, the majority of whom were employed in the State of Delaware. In determining the number of eligible employees, companies, which are affiliated companies, shall be considered one employer.

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20. If you are an employer enrolling 10 through 50 employees in a medical plan, please answer question 20 (a-g) relating to your covered employees, their dependents and COBRA participants. This information will be provided to our Health Management area. Please use a separate sheet of paper if more space is needed. ***Note: Please do not provide the name of any individual. Give details to questions answered "yes."*** As a reminder, if you are enrolling 1 through 9 employees, please submit an Individual Health Questionnaire for each employee.

a.) Are you aware of any individual with a history of frequent or recent medical treatment for:

			# of individuals
Asthma	[ ] Yes	[ ] No	_____
Congestive heart failure	[ ] Yes	[ ] No	_____
Diabetes	[ ] Yes	[ ] No	_____
HIV/AIDS	[ ] Yes	[ ] No	_____
High blood pressure	[ ] Yes	[ ] No	_____
Hip/knee/joint replacement	[ ] Yes	[ ] No	_____
Kidney	[ ] Yes	[ ] No	_____
Liver	[ ] Yes	[ ] No	_____
Mental health/substance abuse	[ ] Yes	[ ] No	_____
Pregnancy	[ ] Yes	[ ] No	_____

b.) Are you aware of any individual who currently smokes or chews tobacco, or has done so within the last 24 months? [ ] Yes [ ] No _____

c.) Are you aware of any individual who has hospitalization, surgery or treatment pending or who has been advised that hospitalization, surgery or treatment is needed? [ ] Yes [ ] No _____

d.) Are you aware of any individual who is disabled? [ ] Yes [ ] No _____

e.) Has any individual been absent for 10 or more consecutive days in the past 12 months due to an illness or injury? [ ] Yes [ ] No _____

f.) Are you aware of any individual who is not actively at work or is confined to any hospital or skilled nursing facility? [ ] Yes [ ] No _____

g.) Please list any claims that you aware of that have exceeded $5,000 in the last 12 months on any individual. Please provide an estimate of the approximate amount paid, medical condition, and the likelihood of future expenses: _____

I have read the AmeriHealth Group Enrollment Form and have completed it accurately. I understand that no insurance will be effective unless and until the application is accepted in writing by AmeriHealth HMO, and AmeriHealth Insurance Company. No contract of insurance is implied in any way on the basis of the submission of this form. I will notify AmeriHealth in writing of any changes to the information provided on this form that occurs prior to the requested effective date.

It is further understood that 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 30 hours per week at his employer's place of business.

Any person who knowingly files a statement of claim, application for insurance, enrollment form, or certification containing any false or misleading information may be subject to criminal and civil penalties.

I understand that, if eligible, commissions on the account will be paid by the carrier and additional compensation known as" override commissions" may be earned from the carrier for meeting overall sales and retention goals.

_____
Date of Signature

_____ _____
Print Name and Title of Officer, Partner or Proprietor | Signature of Officer, Partner or Proprietor

_____ _____
Print Name of Broker | Signature of Broker

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