AmeriHealth PPO Group History Form (DE & NJ)

IDENTIFYING INFORMATION

Customer Name: _____

Customer Identification Number (CID): _____ **Region Code:** ❑ **NJ** ❑ **NN**

SOLD Effective Date: _____/_____/_____ Anniversary Date: _____/_____/_____

GROUP STATUS

❑ Local	❑ National	❑ Broker	❑ Active	❑ Retiree	❑ Association

GROUP INFORMATION

Lead Group # _____ New Group # _____ Existing Group # _____ Affil # _____

Group Name (if other than customer name): _____

Group Address: _____

City, State, Zip: _____

Group Leader: _____ Telephone: ( ) _____

Union/Fund Name: _____ Union/Fund Code: _____ Negotiation Date: _____/_____/____

Rating Contact (if other than group leader): _____ SIC # _____

Number of Eligible Employees: _____ Waivers: _____ Total Number to be Enrolled: _____

Number in AmeriHealth POS/HMO:_____

BILLING INFORMATION

Group Billing: ❑ **Monthly (standard)** Other: _____ List Billing: ❑ **Quarterly (standard)** ❑ Monthly

Billing Address: _____

City, State, Zip: _____

Billing Sort: ❑ **Alphabetical (standard)** ❑ **Payroll Location (standard National)** ❑ Other: _____

REASON FOR GROUP HISTORY

❑ New Business	❑ Conversion	❑ Change	❑ New Group	❑ Additional LOB	❑ Renewal

❑ Transfer _____ subscribers from existing group # _____ to new group # _____

❑ Cancel existing group(s) _____ *OR* ❑ Existing group(s) to remain active

Include new group # in existing affiliation # _____ ❑ Yes ❑ No ❑ Not applicable

Change Affiliation #: ❑ Yes ❑ No If yes, what is new affiliation # _____

❑ Transfer group from existing affiliation _____ to new affiliation # _____

❑ New affiliation, affiliate with group(s): _____

❑ Other: _____

Change group status: ❑ credible ❑ non-credible ❑ Update group benefits (complete group history required)

❑ Add to, or correct previous group history dated ____/____/____ ❑ Add new program: _____

❑ Other:

Claims Fiduciary (Self-Funded Groups Only)

❑ **AmeriHealth** is Claims Fiduciary-**Medical/Ancillary** (self-funded only) Eff Date: ____/____/____

❑ **AmeriHealth** is Claims Fiduciary-**Medical Only** (self-funded only) Eff Date: ____/____/____

❑ **AmeriHealth** is Claims Fiduciary-**Ancillary Only** (self-funded only) Eff Date: ____/____/____

❑ **Group** is Claims Fiduciary (self-funded only) Eff Date: ____/____/____

EMPLOYER PARTICIPATION

Rate Notification: ❑ **60 days (standard)** ❑ 90 days ❑ Other: _____

Participation: ❑ None ❑ 100% ❑ Partial: _____ % *OR* $ Amount: _____

❑ Other: _____

Pre-Existing Waiver: ❑ **Full waiver (standard)** ❑ Initial Enrollees Only ❑ No waiver

DEPENDENT INFORMATION

Dependent Removal: ❑ 1st of Month Following Date of Ineligibility* ❑ 15th of Month Following Date of Ineligibility*

**date of ineligibility is date the dependent reaches limiting age*

NJ Only: ❑ January (end of calendar year) ❑ Anniversary ❑ Other: _____

Dependent Eligibility: ❑ _____ th birthday/ _____ birthday if full time student *(complete only if other than 19/23, which is standard)*

Removed By: ❑ AmeriHealth Insurance Company ❑ Group ❑ Shared

Removal Method: ❑ Verification (standard) ❑ Certification How Often?

Prior Carrier Name: _____ Code: _____

RATING STATUS

Fully Insured: ❑ Community based, age, sex (51-99) ❑ Prospective ❑ Retrospective

Cost-Plus: ❑ Rate Basis ❑ Claims Reimbursement Basis

Stop Loss: ❑ Yes ❑ No ❑ Specific $ _____ ($75,000 is the standard)

❑ Aggregate _____% (125% is the standard)

Tier Structure: ❑ 5 Tier ❑ **4 Tier (standard)** ❑ 3 Tier ❑ 2 Tier ❑ Composite

RATING - SPECIAL FINANCIAL ARRANGEMENTS

❑ 90% Contingency ❑ 60-Day Delayed ❑ Staggered Premium

❑ Other (*explain*):

PPO PROGRAM OPTIONS

DELAWARE

Standard	Value Series	High Deductible Series
❑ 5	❑ 5/15/70%	❑ 520/80%/50%
❑ 10	❑ 10/20/70%	❑ 1020/80%/50%
❑ 15	❑ 15/25/70%	❑ 2020/80%/50%
❑ 310	❑ 20/30/70%	❑ 2520/80%/50%
	❑ 20/30/60%	

Group Specific
❑ PPO Group-Specific
Identify Base Plan: _____
(Attach approved Benefit Exception)

***Flex Programs* (available 4-1-2004)**

Copay	Facility	Out-of-Network
❑ Copay 1	❑ Facility 1	❑ Out-of-Network 1
❑ Copay 2	❑ Facility 2	❑ Out-of-Network 2
❑ Copay 3	❑ Facility 3	
	❑ Facility 4	

Connections[sm] Health Management Program (available 6-1-2004)
❑ **Add** Connections[sm] Health Management (self-funded groups only)
❑ **Exclude** Connections[sm] Health Management (self-funded groups only)

❑ AmeriHealth Administrators HRA

NEW JERSEY

Standard	Value Series	High Deductible Series
❑ 5	❑ 5/15/70%	❑ 520/80%/50%
❑ 10	❑ 10/20/70%	❑ 1020/80%/50%
❑ 15	❑ 15/25/70%	❑ 2020/80%/50%
❑ 20	❑ 20/30/70%	❑ 2520/80%/50%
❑ 310		
❑ 320		

Group Specific
❑ PPO Group-Specific
Identify Base Plan: _____
(Attach approved Benefit Exception)

Connections[sm] Health Management Program (available 6-1-2004)
❑ **Add** Connections[sm] Health Management (self-funded groups only)
❑ **Exclude** Connections[sm] Health Management (self-funded groups only)

❑ AmeriHealth Administrators HRA

PRESCRIPTION DRUG OPTIONS RIDER

DELAWARE

Standard Drug	Select Drug	Select Drug	Deductible/ Coinsurance Drug
(1+)	(1+)	(100+)	(1+)
❑ $5/$10	❑ $5/$10/$25	❑ $5/$10/$35	❑ $150/20%/$2,000
❑ $6/$10	❑ $5/$15/$25	❑ $5/$10/$50	❑ $250/20%/$2,000
❑ $5/$20	❑ $5/$20/$35	❑ $5/$15/$35	❑ $200/30%/$3,000
❑ $10/$15	❑ $10/$20/$35	❑ $5/$15/$50	(100+)
❑ $10/$20	❑ $10/$30/$50	❑ $5/$20/$50	❑ $100/20%/$2,000
❑ 50%/50%	❑ $15/$35/$50	❑ $10/$20/$50	❑ $200/20%/$2,000
(100+)	❑ $20/$40/$60	❑ $10/$30/$50	❑ $150/30%/$3,000
❑ $2/$6		❑ $15/$35/$50	
❑ $4/$8		❑ $20/$40/$60	
		❑ $5/$10/50%	
		❑ $5/$15/50%	
		❑ $5/$20/50%	

❑ Exclude Contraceptives
❑ Other (Rx Benefit Exception required): _____

NEW JERSEY

Standard Drug	Select Drug	Select Drug	Deductible/ Copayment Drug
(51+)	(51+)	(100+)	(51+)
❑ $5/$10	❑ $5/$10/$25	❑ $5/$10/$35	❑ $100/$15/$15
❑ $8/$15	❑ $5/$15/$25	❑ $5/$10/$50	❑ $100/$15/$25
❑ 50%/50%	❑ $5/$20/$35	❑ $5/$15/$35	❑ $200/$15/$15
(100+)	❑ $10/$20/$35	❑ $5/$15/$50	❑ $200/$15/$25
❑ $1/$3		❑ $5/$20/$50	❑ 100/$15/$25/$35
❑ $2/$6		❑ $10/$20/$50	❑ 200/$15/$25/$35
❑ $4/$8		❑ $5/$10/50%	
		❑ $5/$15/50%	
		❑ $5/$20/50%	

Drug Retail Dispensing
❑ 90 Day/3 Copays or Coinsurance
(For Deductible/Copay Program, Deductible must be met first)

❑ 90 day or 100 units whichever is greater/1 Copay or Coinsurance (Standard Drug Only)
❑ Other:_____

❑ Exclude Contraceptives
❑ Other (Rx Benefit Exception required): _____

BROKER AND CONSULTANT INFORMATION

❑ Broker ❑ Consultant Broker of Record Letter on file: ❑ Yes ❑ No All AmeriHealth? ❑ Yes ❑ No

Producing Agent Name: _____ Telephone: ( ) _____

Producing Agency Name: _____

Primary Broker Name: _____

Firm Name: _____

City, State, Zip: _____

COMMISSION

First Year: _____ % Effective Date: _____/_____/_____ Renewal: _____ %

ENROLLMENT APPLICATIONS

Applications Attached: ❑ Yes ❑ No If No, to follow by: _____/_____/_____
List of Subscribers Attached: ❑ Yes ❑ No
Tape Enrollment: ❑ No ❑ Yes If Yes, ❑ Initial ❑ Ongoing
Check Submitted: ❑ No ❑ Yes, Amount: $ _____

MEDICARE SUPPLEMENT (DELAWARE ONLY) **EFFECTIVE DATE:** _____/_____/_____

❑ Plan A ❑ Plan B ❑ Plan C ❑ Plan E ❑ Plan F ❑ Plan I

PROTECTION STARTS/ENDS

Protection Starts: ❑ Date of Hire ❑ 30 Days ❑ 60 Days ❑ 90 Days
❑ Other (*explain*): _____

Protection Ends (*explain*): _____

Eligibility (1st or 15th of Month After) ❑ Date of Hire ❑ 30 Days ❑ 60 Days ❑ 90 Days
❑ Other (*explain*): _____

IDENTIFICATION CARDS

ID Card Number: ❑ Social Security Number **(standard)** ❑ Certificate Number ❑ Other
Mail ID Cards To: ❑ Member **(standard)** ❑ Group or Fund ❑ Other
Sort: ❑ Alphabetically **(standard)** ❑ Payroll Location ❑ Other
ID Cards Sets: ❑ Standard (1 Card for Single Contract, 2 Cards for All Others) ❑ Double (2 Cards for Single Contract, 4 Cards for All Others)
Special ID Card Message: ❑ No ❑ Yes **If Yes, attach IC Request Form and provide mock-up of front of ID card**.

BOOKLETS

Booklet included in Welcome Kit: ❑ Yes **(standard)** ❑ No
Booklet Logo: ❑ No ❑ Yes Custom Booklet: ❑ No ❑ Yes
Custom Booklet Cover Name (*if applicable*): _____
Draft Required: ❑ No ❑ Yes If Yes, Date Draft Required: _____/_____/_____
Send Draft To (*if applicable*): _____

WELCOME KITS ❑ **DELAWARE** ❑ **NEW JERSEY**

Kits Required: ❑ Yes **(standard)** ❑ No Mail Kits To: ❑ Member **(standard)** ❑ Group or Fund ❑ Other *(specify)*:

DELAWARE **Total enrolled by option:**

Standard	Value Series	High Deductible Series
5 _____	5/15/70% _____	520/80%/50%: _____
10 _____	10/20/70% _____	1020/80%/50% _____
15 _____	15/25/70% _____	2020/80%/50% _____
310 _____	20/30/70% _____	2520/80%/50% _____
	20/30/60% _____	

Group Specific
PPO Group-Specific: _____

Flex Programs **(available 4-1-2004)**

C1F1O1._____	C1F1O2. _____	C1F2O1._____	C1F2O2 ._____
C1F3O1._____	C1F3O2 ._____	C1F4O1._____	C1F4O2 ._____
C2F1O1._____	C2F1O2 ._____	C2F2O1._____	C2F2O2 ._____
C2F3O1._____	C2F3O2 ._____	C2F4O1._____	C2F4O2 ._____
C3F1O1._____	C3F1O2 ._____	C3F2O1._____	C3F2O2 ._____
C3F3O1._____	C3F3O2 ._____	C3F4O1._____	C3F4O2 ._____

NEW JERSEY **Total enrolled by option:**

Standard	Value Series	High Deductible Series
5 _____	5/15/70% _____	520/80%/50%: _____
10 _____	10/20/70% _____	1020/80%/50% _____
15 _____	15/25/70% _____	2020/80%/50% _____
20 _____	20/30/70% _____	2520/80%/50% _____
310 _____		
320 _____		

Group Specific
PPO Group-Specific: _____

FREESTANDING DRUG – DELAWARE/NEW JERSEY **AFFIL #** **EFFECTIVE DATE:**

❑ Employee Only
❑ Employee & Dependents
Dependent Children To Age: _____
Dependent Students To Age: _____
Include (check only those that apply for the programs below)
❑ Contraceptives

Drug Retail Dispensing (NJ)
❑ 90 Day/3 Copays or Coinsurance
(For Deductible/Copay Program, Deductible must be met first)
❑ 90 Day/1 Copay (Standard Drug Only)
❑ Other:_____ (Rx Benefit Exception required)

Standard Drug 51+
❑ $1/$3 **(NJ Only)**
❑ $2/$6 **(NJ Only)**
❑ $2/$10
❑ $4/$8 **(NJ Only)**
❑ $5/$10
❑ $5/$15
❑ $5/$20
❑ $6/$10
❑ $8/$14 **(NJ Only)**
❑ $10/$15 **(DE Only)**
❑ $10/$20
❑ 80%/20% **(DE Only)**
❑ 50%/50%

Select Drug 51+ (NJ/DE)
❑ $5/$10/$25
❑ $5/$10/$35
❑ $5/$10/$50
❑ $5/$15/$25
❑ $5/$15/$35
❑ $5/$15/$50
❑ $5/$20/$35
❑ $5/$20/$50
❑ $10/$20/$35
❑ $10/$20/$50
❑ $10/$30/$50 **(DE Only)**
❑ $15/$35/$50 **(DE Only)**
❑ $20/$40/$60 **(DE Only)**
❑ $5/$15/50%
❑ $5/$20/50%
❑ $5/$10/50%

Deductible/Coinsurance (DE)
❑ $100/20%/$2,000
❑ $150/20%/$2,000
❑ $200/20%/$2,000
❑ $250/20%/$2,000
❑ $150/30%/$3,000
❑ $200/30%/$3,000

Deductible/Copayment (NJ)
❑ $100/$15/$15
❑ $100/$15/$25
❑ $200/$15/$15
❑ $200/$15/$25
❑ $100/$15/$25/$35
❑ $200/$15/$25/$35

VISION-ADMINISTERED BY DAVIS VISION AFFIL # **EFFECTIVE DATE:**

❑ Employee Only
❑ Employee & Dependents
❑ Dependent Children Covered To Age: _____
❑ Dependent Students Covered To Age: _____

Frames/Lenses	Code
❑ $35	_____
❑ $100	_____
❑ $200	_____
❑ $250	_____

❑ 1 Every Calendar Year
❑ 1 Every 2 Calendar Years

LOCATION NAME _____ **PAYROLL LOCATION #** _____

RATES

ALL RATES QUOTED FOR _____ **THROUGH** _____

	Single	EE/Child	EE/Children	Two Person	Family	Total Composite
PPO Option _____ **Rating Type:** ❑ Community/age/sex (51-99) ❑ Prospective ❑ Retrospective						
PPO *Flex Program* Option **(DE only)** C _____ F _____ O _____ Rating Type: ❑ Community/age/sex (51-99) ❑ Prospective ❑ Retrospective						
PPO RX Standard Drug _____ _____ Select Drug _____ _____ _____ Ded/Coin (DE) _____ _____ _____ Ded/Copay (NJ) _____ _____ _____ _____ **Rating Type:** ❑ Community, age, sex (51-99) ❑ Prospective ❑ Retrospective						
FREESTANDING RX Standard Drug _____ _____ Select Drug _____ _____ _____ Ded/Coin (DE) _____ _____ _____ Ded/Copay (NJ) _____ _____ _____ _____ **Drug Retail Dispensing (NJ)** ❑ 90 Day/3 Copays or Coinsurance ❑ 90 Day/1 Copay or Coinsurance (Standard Drug Only) ❑ Other:_____ **Rating Type:** ❑ Community, age, sex (51-99) ❑ Prospective ❑ Retrospective						
DAVIS VISION ❑ $35 ❑ $100 ❑ $200 ❑ $250 ❑ 1every calendar year ❑ 1 every 2 calendar years **Rating Type:** ❑ Community, age, sex (51-99)						
MEDICARE SUPPLEMENT ❑ Plan A ❑ Plan B ❑ Plan C ❑ Plan E ❑ Plan F ❑ Plan I						
CARVEOUT **Rating Type:**						

Sales Representative: _____ **Code:** _____ **Date:** _____

Approved by Sales Manager: _____ **Date:** _____