

AmeriHealth New Jersey Application for Individual Coverage

APPLY

AmeriHealth New Jersey
259 Prospect Plains Rd, Building M
Cranbury, NJ 08512

A. Type of Activity – To be completed by Applicant. *Refer to instructions before completing this form. Print clearly.*

Activity – Check all that apply		Date of Event	Reason
ADD	<input type="checkbox"/> Enrollment of a new Subscriber	____/____/____	_____
	<input type="checkbox"/> Add Spouse	____/____/____	_____
	<input type="checkbox"/> Add Civil Union Partner	____/____/____	_____
	<input type="checkbox"/> Add Domestic Partner	____/____/____	_____
	<input type="checkbox"/> Add Dependent Child	____/____/____	_____
REMOVE	<input type="checkbox"/> Remove Spouse	____/____/____	_____
	<input type="checkbox"/> Remove Civil Union Partner	____/____/____	_____
	<input type="checkbox"/> Remove Domestic Partner	____/____/____	_____
	<input type="checkbox"/> Remove Dependent Child	____/____/____	_____
OTHER CHANGES	<input type="checkbox"/> Name Change	____/____/____	_____
	<input type="checkbox"/> Change Plan	____/____/____	_____
	<input type="checkbox"/> Special Enrollment Period (following a Triggering Event*)	____/____/____	_____
	<input type="checkbox"/> Other	____/____/____	_____
	<input type="checkbox"/> Add/Change Office ID Numbers: Primary/OB/Gyn/Dentist <i>* See list of Triggering Events in Instructions</i>	____/____/____	_____

B. Applicant Information

Name (Last, First, MI):		SSN:	Birthdate (mm/dd/yyyy)
<input type="checkbox"/> Male <input type="checkbox"/> Female	Are you a resident of New Jersey? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you maintain a home in any other state or country? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Name of State/Country: _____ Number of months you live there each year: _____	
Address Information	Primary Residence: Street/Apt: _____ Street/Apt: _____ City: _____ State: _____ Zip Code: _____ Phone: (____) _____		
	Other Residence: Street/Apt: _____ Street/Apt: _____ City: _____ State: _____ Zip Code: _____ Phone: (____) _____		
	Your billing address: <input type="checkbox"/> Primary residence <input type="checkbox"/> Other residence <input type="checkbox"/> P.O. Box or Other (<i>specify</i>):		
Activity	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Other Change <input type="checkbox"/> Continue <i>If a name change, indicate prior name:</i>		
	Primary Loc #: _____	NPI or PCP ID #: _____	
	Address: _____	_____	
	Ob/Gyn Loc #: _____	NPI or PCP ID #: _____	
	Address: _____	_____	
	Dentist Loc #: _____	NPI or PCP ID #: _____	
	Address: _____	_____	
Are you eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you covered under any health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, why are you applying for individual coverage? _____	

C. Insert Plan Options:

Medical Plan Name:

Family Dental – Required (See instruction page for details)

Adult Vision 100 Adult Vision 150 Adult Vision 180

D. Other Individuals Covered – Identify individuals other than yourself for whom you are adding/changing/removing coverage. Attach additional pages if necessary, dated and signed by you. Attach proof of disability if necessary.

1. Spouse/Domestic Partner/ Civil Union Partner	2. Child	3. Child	4. Child
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Other	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Other	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Other	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Other
Name (last, first, MI) L: _____ F: _____ MI: _____	Name (last, first, MI) L: _____ F: _____ MI: _____	Name (last, first, MI) L: _____ F: _____ MI: _____	Name (last, first, MI) L: _____ F: _____ MI: _____
Birthdate (mm/dd/yyyy): ____ / ____ / ____	Birthdate (mm/dd/yyyy): ____ / ____ / ____	Birthdate (mm/dd/yyyy): ____ / ____ / ____	Birthdate (mm/dd/yyyy): ____ / ____ / ____
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security Number: _____	Social Security Number: _____	Social Security Number: _____	Social Security Number: _____
Eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No Covered under any health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No Covered under any health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No Covered under any health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No Covered under any health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Care Provider: NPI or PCP ID #: _____ Address: _____ _____ _____	Primary Care Provider: NPI or PCP ID #: _____ Address: _____ _____ _____	Primary Care Provider: NPI or PCP ID #: _____ Address: _____ _____ _____	Primary Care Provider: NPI or PCP ID #: _____ Address: _____ _____ _____
Ob/Gyn Office: NPI or PCP ID #: _____ Address: _____ _____ _____	Ob/Gyn Office: NPI or PCP ID #: _____ Address: _____ _____ _____	Ob/Gyn Office: NPI or PCP ID #: _____ Address: _____ _____ _____	Ob/Gyn Office: NPI or PCP ID #: _____ Address: _____ _____ _____
Dentist Office: NPI or PCP ID #: _____ Address: _____ _____ _____	Dentist Office: NPI or PCP ID #: _____ Address: _____ _____ _____	Dentist Office: NPI or PCP ID #: _____ Address: _____ _____ _____	Dentist Office: NPI or PCP ID #: _____ Address: _____ _____ _____
If last name is different from Applicant, please explain: _____ _____	If last name is different from Applicant, please explain: _____ _____	If last name is different from Applicant, please explain: _____ _____	If last name is different from Applicant, please explain: _____ _____
Home address same as Applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If NO, complete Section E</i>	Home address same as Applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If NO, complete Section E</i>	Home address same as Applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If NO, complete Section E</i>	Home address same as Applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If NO, complete Section E</i>

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

a. Street/Apt: _____
Street/Apt: _____
City, State, Zip Code: _____

b. Please explain why the address is different: _____

F. Additional Child Information – Provide information below about children listed in Section D, if they have a different address. If multiple children reside at an address, you may list them together. Attach additional pages as necessary, signed and dated.

Name(s): _____
Street/Apt: _____
Street/Apt: _____
City, State, Zip Code: _____

Name(s): _____
Street/Apt: _____
Street/Apt: _____
City, State, Zip Code: _____

G. Race / Ethnicity – Response is appreciated but NOT required!

Choose a category that most closely describes you: American Indian or Alaskan Native Black, not of Hispanic origin Hispanic
 Asian or Pacific Islander White, not of Hispanic origin

H. Payment Information – Indicate how you would like to be billed and make payment.

Monthly Check Money Order

I. Applicant's Signature

I represent that all the information supplied in this application is true and complete.
I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form

Signature: _____ Date: ____ / ____ / ____

J. Broker/General Agent Signature

Signature of Preparer: _____	Date: ____ / ____ / ____	NJ Producer License #
General Agent: _____		Agent ID #

INSTRUCTIONS AND ELIGIBILITY REQUIREMENTS

Instructions

- Except for section G, you must complete sections A through I, and sign and date this form, as well as any additional pages you may need to submit with it to provide further requested information.
- Please PRINT except when a signature is requested.
- If a dependent child is disabled and you want to continue his or her coverage beyond age 26, describe this in "Other Change" in Section A, and attach proof of disability.
- If you are applying to add a spouse, civil union partner, domestic partner, or child please check the applicable box in the "Add" section in A **and** identify the applicable triggering event in the reason section "Other Change" section in A.
- You can obtain the providers' correct names and addresses from the appropriate provider directory. You may also obtain each provider's NPI number or PCP ID from the provider directory or by contacting the provider directly. Providers with multiple office locations and individual providers who belong to more than one practice or provider entity may have more than one NPI number. You should confirm the correct NPI number for the specific provider and office location where you will be seen by contacting that office directly.
- For provider addresses, include the zip code plus the four digit extension (9 digits).
- IF YOU HAVE ANY QUESTIONS concerning the benefits and services provided by or excluded under this policy, contact a member services representative at 1-800-877-9829 before signing this form.
- KEEP A COPY OF THIS COMPLETED APPLICATION! A copy of this application may be used as a temporary ID card for 30 days from the effective date if authorized by. Coverage must be verified prior to visiting with a specialist or you may also register on amerihealthexpress.com and print a temporary ID card that is valid for 10 days.
- Triggering Events:
 1. Loss of eligibility for minimum essential coverage but not if lost due to non-payment of premium.
 2. Dependent attained age 26 or 31 and lost coverage.
 3. Marketplace changed your subsidy determination.
 4. New dependent due to marriage, birth, adoption or placement for adoption, or placement in foster care.
 5. Gained access to New Jersey plans as a result of permanent move to New Jersey.
 6. In 2014 only, non-renewal of current individual coverage; enrollment may be requested within the 30 days prior to the non-renewal of the current coverage. Check the "Other Change" section in A.

Eligibility

- A. Eligibility requirements are set forth under the Individual Health Coverage Reform Act of 1992, P.L. 1992, c. 161 (N.J.S.A. 17B:27A-2 et seq.).
- B. You **MUST** be a New Jersey resident which means your primary residence is in New Jersey.
- C. You must **NOT** be eligible for Medicare.
- D. If application is made for the Catastrophic Plan the following additional requirements apply:
 1. You must be under 30 years old; OR
 2. You must have a Certificate of Exemption from the Marketplace. Attach a copy to your application.
- E. The **Annual Open Enrollment Period** runs from October 15 through December 7 each year. Your application must be received during this time period. During the Annual Open Enrollment Period you may apply for or change coverage for yourself and family members who are currently uninsured or who are covered under another individual plan, or who are covered under a group health plan, group health benefits plan, a governmental plan, or a church plan. The effective date of coverage will be January 1 of the calendar year following the Annual Open Enrollment Period.
- F. The **Initial Enrollment Period** runs from October 1, 2013 through March 31, 2014. Your application must be received during this time period. During the Initial Enrollment Period you may apply for coverage for yourself and family members who are currently uninsured or who are covered under another individual plan, or who are covered under a group health plan, group health benefits plan, a governmental plan, or a church plan. The effective date of coverage will be January 1, 2014 or January 15, 2014 if the application is received by December 31, 2013 and for applications received after December 31st will be the first of the month following receipt of the application.
- G. A **Special Enrollment Period** that lasts for 60 days follows the Triggering Events listed above. The effective date of a new policy will be no later than the first of the month following receipt of the application.
- H. NOTE: If you currently have coverage, the plan for which you are applying must **REPLACE** the current coverage but you **SHOULD NOT** terminate it until the new coverage is effective.

CONDITIONS OF ENROLLMENT – APPLICANT ACKNOWLEDGEMENTS AND AGREEMENTS

On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer reporting agency, and any employer to give AmeriHealth New Jersey, or any consumer reporting agency acting on behalf of AmeriHealth New Jersey, information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that AmeriHealth New Jersey has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one.
4. I agree AmeriHealth New Jersey will provide coverage in accordance with the terms of the contract for the individual plan.
5. I understand that my enrollment and the enrollment of my listed dependents in AmeriHealth New Jersey's individual plan are subject to acceptance by AmeriHealth New Jersey.
6. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the individual plan if premiums are not paid timely.

MISREPRESENTATIONS

Any person who includes any false or misleading information on a Nongroup Enrollment/Change Request Form for a health benefits plan is subject to criminal and civil penalties.

IMPORTANT: The Patient Protection and Affordable Care Act (PPACA) requires that you have pediatric dental coverage. To help you meet that requirement we have pre-selected our Smile for Health Family C40A50 dental plan which provides coverage for you and any eligible family members including pediatric dental coverage as required by PPACA. If you do not select the Smile for Health Family C40A50 dental plan, you will need to provide proof of coverage in another Pediatric Dental plan to ensure that you meet the Federal requirements under PPACA.

