Group # ________________
Group Name ____________
Effective Date ____________
Disenroll Date ____________

AmeriHealth 65℠
GROUP ENROLLMENT APPLICATION/CHANGE FORM WITH CHOICE OPTION

I understand that neither Medicare nor AmeriHealth will pay for services if they are not provided by a plan physician or arranged for by a plan physician and approved by AmeriHealth in advance, except in emergency or urgent cases.

A *AmeriHealth 65 enrollment information*–Your Primary Care Physician selection must be made from the AmeriHealth 65 Physician Directory.

Would you prefer us to send you information in a language other than English? If yes, language ____________________

Please PRINT your name and address below: **NEW JERSEY**
Name ________________________________
Address ________________________________
____
City ____________ State________ Zip__________

Social Security No.:
County:
Home Phone: (   )
Date of Birth:
Sex: ☐ Male ☐ Female

Past Employer

Present Marital Status
☐ Single ☐ Separated ☐ Married ☐ Widowed ☐ Divorced

Primary Dental Office Name

E-Mail Address

Last Name, First, M.I.	Date of Birth	Sex	Social Security Number	Primary Care Physician Name If Current Physician Check Box	✔	Physician Code Number
Subscriber						
Spouse						
Child						

B *Requested Action – Please print clearly*

ADDITIONS
☐ New Subscriber
❏ Enroll me in AmeriHealth 65
❏ Enroll me in the AmeriHealth 65 Choice Option
☐ Add Spouse
❏ Enroll my spouse in AmeriHealth 65
❏ Enroll my spouse in AmeriHealth 65 Choice Option

CHANGES
☐ Name
☐ Address

TERMINATION
☐ Deceased
☐ Termination From Plan
☐ Divorced
☐ Terminate Spouse

Desired effective date ________/________/________

C *Please answer the following questions:*

Are you…	Subscriber		Spouse	
* Medicaid eligible? If yes, give Medicaid # ______________	Yes	No	Yes	No
* Residing in a Nursing Home or Foster Care Home or other institution?	Yes	No	Yes	No
You cannot be denied enrollment if you answer yes to any of the above questions.				
* Suffering from End-Stage Renal Disease? (Kidney disease or transplant)	Yes	No	Yes	No

D *Other insurance*

Current Health Insurance: ____________________
☐ Blue Cross/Blue Shield ☐ Aetna/U.S. Healthcare ☐ AARP
☐ AmeriHealth ☐ Other ____________________
Do you have a PAAD card? ☐ Yes ☐ No
Are you or your spouse employed? ☐ Yes ☐ No
Name of company/ies: ____________________

E *Emergency information*

Please print the name and telephone number of the closest relative or friend to be contacted in case of emergency.

____
Name Telephone

F *Copy this information directly from your Medicare card*

SUBSCRIBER INFORMATION

Health Insurance

CLAIM NUMBER
SOCIAL SECURITY ACT
[| |] – [|] – [| | |] – [   ]

IS ENTITLED TO — EFFECTIVE DATE
HOSPITAL INSURANCE PART A [|] – [   ] – [|]
MEDICAL INSURANCE PART B [|] – [   ] – [|]

SPOUSE INFORMATION

Health Insurance

CLAIM NUMBER
SOCIAL SECURITY ACT
[| |] – [|] – [| | |] – [   ]

IS ENTITLED TO — EFFECTIVE DATE
HOSPITAL INSURANCE PART A [|] – [   ] – [|]
MEDICAL INSURANCE PART B [|] – [   ] – [|]

G *Important: Read back of Enrollment Form and sign below.*

Signature (Beneficiary or authorized representative)† ____________________ Date__________
Signature (spouse Beneficiary or authorized representative)† ________________ Date__________
†Authorized representative must provide supporting documentation; for example, copy of durable power of attorney papers.

Please keep the gold copy of this enrollment form as temporary ID, valid for 90 days from enrollment date.

Employer Signature ____________________ Date____________
If anyone helped you fill out this form, he or she must sign the following line:
Signature______________________________ Date______________ Relationship to Beneficiary ____________

I UNDERSTAND THAT THE FOLLOWING STATEMENTS ARE A PART OF MY CONTRACT WITH AMERIHEALTH.

1. I understand that Medigap insurance or other supplemental insurance is no longer necessary because AmeriHealth 65 pays the deductible and coinsurance usually paid by Medigap. However, I understand that I may either keep my current policy or cancel it if I am satisfied with AmeriHealth 65. I also understand that I will generally not need a Medigap policy if I enroll in a Medicare contracting health plan; however, a Medigap policy could be of value to me if I leave AmeriHealth 65 and return to Fee-For-Service Medicare.
2. By enrolling in a Medicare+Choice plan, I hereby authorize the Health Care Financing Administration (HCFA) to provide information to AmeriHealth confirming my entitlement to Hospital Insurance Benefits (Part A) and to any supplementary Medical Insurance Benefits (Part B) under Title XVIII (The Medicare Program) of the Social Security Act.
3. I hereby authorize AmeriHealth and its contracted providers, or any other holder of medical or other relevant information about myself, to release to HCFA or HCFA's agents information needed to administer Title XVIII of the Social Security Act.
4. I understand that I am required to select a personal physician from the AmeriHealth 65 physician directory and, that I am required to have my physician provide or arrange for all the medical services I need. I understand that, except for emergencies and urgently needed care, unauthorized services received will not be covered.
5. I understand that it is my responsibility to inform AmeriHealth prior to moving or leaving the service area for more than 12 months, and that my absence means that AmeriHealth may take action to disenroll me from AmeriHealth 65 and return me to traditional Medicare coverage.
6. I authorize AmeriHealth to obtain from my providers of service and hospitals, the medical records relating to the administration of my contract with AmeriHealth.
7. I understand that the benefits I will be eligible for are described in the AmeriHealth 65 Member Handbook and that the AmeriHealth marketing materials are only a summary. A full explanation of my benefits are detailed in the Member Evidence of Coverage.
8. I understand that the submission of false or misleading information or the omission of material information on this form may result in rejection of my application, or disenrollment.
9. I understand that I may disenroll from AmeriHealth 65 by sending a written request to AmeriHealth, the Social Security Office, or the Railroad Retirement Board. Until the effective date of disenrollment, I must continue to receive health care from AmeriHealth 65 contracted providers.
10. I understand that I may cancel my enrollment in AmeriHealth 65 at any time. If I decide to cancel my enrollment, my premium, if any, will be refunded. I understand that my termination will become effective the first month following receipt of my written request by AmeriHealth. Until the effective date of disenrollment, I must continue to receive health care from AmeriHealth 65 contracted providers.
11. If I select the Point of Service option, I am required to select a Primary Care Physician, and receive all routine and Preventive Care from my Primary Care Physician.
12. I understand that while the "effective date of coverage" on the first page of this form is when I should begin using AmeriHealth 65 plan services, AmeriHealth 65 will still be sending me final confirmation of my enrollment. I understand that I should not disenroll from any Medicare supplemental plan or Medigap/Medicare Select plan until I receive confirmation of my enrollment from AmeriHealth 65.
13. I warrant that the information on this form is true, correct and complete.
14. 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 materially 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.
15. I understand that I can be a member of only one Medicare+Choice plan at a time. By enrolling in AmeriHealth 65, I will automatically be disenrolled from any other Medicare+Choice plan of which I am currently a member. I also understand that since I can be a member of only one Medicare+Choice plan at a time, I cannot enroll in more than one Medicare+Choice plan with the same effective date of coverage. If I do this, my enrollment will be canceled and I will have to fill out a new enrollment form to become a member of a Medicare+Choice plan.
16. I understand I must maintain my Medicare Part A and Part B insurance by continuing to pay the Part B premiums and the Part A premiums, it applicable.
17. I understand that as a member of AmeriHealth 65, I have the right to appeal service and payment denials made by the plan.
18. If I am unable to sign, (1) a court-appointed Legal Guardian or (2) person having Durable Power of Attorney for Health Care (DPAHC) or designated in a written advance directive, if authorized by state law, must sign the application. A copy of the proof of Legal Guardian, DPAHC, written advance directive, or proof of authorization by state law must be attached.