AmeriHealth

INSTRUCTIONS

Group Administrator

- Complete the Group Administrator Group information in the upper left corner of the form.
- **Section A – Type of Activity:** Check boxes indicating reason(s) for submitting application.
- Complete Section I – Employer Verification in the lower left corner of the form.
  - Employer must complete this section for all new enrollments, coverage changes and terminations.
  - Employer must sign and date the Enrollment/Change Request in order for it to be processed.

Employee – Complete Sections B-H

Section B – Employee Information:

- Complete all information in order for your application to be processed.

Section C – Plan Option:

- Indicate Plan Option Name and Copay and/or Individual Deductible Amount.
- Select only an option offered by your employer.

Section D – Individuals Covered:

- Add/Change/Remove – Use “A”, “C”, or “R” to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependents, if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
- If a dependent is a full-time post-secondary student, you must attach a current course schedule or a letter from the school confirming full-time student status. If dependent is disabled and being continued beyond the limiting age, attach proof of disability.
- If you or your dependent(s) have other Health or Rx drug coverage, check off the “Yes” box(es) and complete Section E – Other/Previous Insurance.
- From the appropriate provider directory, locate the 9-digit office ID number for the primary care physician (except PPO).
- Indicate office ID number selection(s) on the form.
- If you are a current patient, please check the “Current Patient” box.

Section E – Other/Previous Insurance:

- Complete this section for all new enrollments or coverage changes. Coverage includes group coverage, governmental coverage, a church plan or Medicare.

Section F – Dependent Information:

- Complete this section for all new enrollments or coverage changes.

Section G – Race/Ethnicity:

- Responding to this question is optional and NOT required.
- Complete this section for all new enrollments.

Section H – Employee Signature:

- Complete this section for all new enrollments, coverage changes and terminations.
- Employee must sign and date the Enrollment/Change Request Form in order for it to be processed.

Section I – Employer Verification:

- Employer must complete this section for all new enrollments, coverage and terminations.
- Employer must sign and date the Enrollment/Change Request Form in order for it to be processed.

Conditions of Enrollment

Employer Acknowledgement and Agreements

On behalf of myself and the dependents listed I agree to or with the following:

1. a) I authorize the sources stated below to give to AmeriHealth, or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition. Authorized sources are any physician or medical professional; any hospital, clinic or other medical care institution; any carrier; any consumer reporting agency; any employer.
   b) I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which [carrier] has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
   c) I know that I have a right to receive a copy of the authorization if I request one.
   d) I agree that a photocopy of this authorization is as valid as the original.
2. I acknowledge by enrolling in an AmeriHealth group plan coverage is provided by AmeriHealth in accordance with the contract.
3. Enrollment of myself and of the listed dependents into the plan is effective on acceptance by AmeriHealth.
4. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. My employer is hereby authorized to withhold payments from my wages, as appropriate.

Misrepresentation

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

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AmeriHealth

ENROLLMENT/CHANGE REQUEST

Send to: AmeriHealth Enrollment
P.O. Box 42555
Philadelphia, PA 19101-2555

Group Information – To be completed by Group Administrator

Group Name | Group Number | Account Number

A Type of Activity – To Be Completed by Group Administrator. Refer to instructions before completing this form. Print clearly.

1. Enrollment Effective Date Date of Hire

☐ New Enrollee/Subscriber

2. Change – Check all that apply

	Date of Event	Reason
☐ Add Spouse		
☐ Add Domestic Partner		
☐ Add Dependent Child		
☐ Name Change		
☐ Change Plan		
☐ Other		
☐ Add/Change Office ID Numbers: Primary		

3. Remove or Terminate – Check all that apply

	Effective Date	Reason
☐ Remove Spouse*		
☐ Remove Domestic Partner*		
☐ Remove Dependent Child*		
☐ Employee Withdrawal/Termination		

Note: Subscriber must be enrolled for spouse/dependents to have coverage.
*Please complete *Add/Change/Remove* and *Name* columns in Section D.

4. Continuation of Coverage, i.e. COBRA, State, total disability. Not all options are available or applicable. Contact Employer for available options.

Coverage for ☐ Employee ☐ Dependents

Length of continuation: ☐ 12 mos. ☐ 18 mos. ☐ 29 mos. ☐ 36 mos. ☐ total disability*

Date of Loss of Coverage: Date of Qualifying Event:

*Attach proof of total disability

B | Employee Information – Complete Sections B-H

Last Name | First Name | M.I. | Date of Employment | Hours worked per week

Social Security Number | Home Telephone | E-mail Address

Home Address | Apartment Number | City | State | ZIP Code

Employer Name | Work Telephone

Work Address | City | State | ZIP Code

C | Plan Option – Your selection must be offered by your Employer

Check one: Indicate Plan Names / Copays / Deductibles / Coverage Status

PPO | HMO | POS | POS + | HMO +

CMM | Vision | RX | HSA

Employment Status

☐ Active

☐ Retiree ☐ COBRA

D | Individuals Covered – List Individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. Attach proof if full-time post-secondary student. Attach proof of disability.

Employee (A)dd / (C)hange / (R)emove | Last Name | First Name | M.I. | Sex M/F | Birthdate MM/DD/YYYY

Social Security Number | Other Health Coverage | Primary Office ID Number | Current Patient | Previous Coverage (check if yes)

Domestic Partner (A)dd / (C)hange / (R)emove | Last Name | First Name | M.I. | Sex M/F | Birthdate MM/DD/YYYY

Social Security Number | Other Health Coverage | Primary Office ID Number | Current Patient | Previous Coverage (check if yes)

Spouse (A)dd / (C)hange / (R)emove | Last Name | First Name | M.I. | Sex M/F | Birthdate MM/DD/YYYY

Social Security Number | Other Health Coverage | Primary Office ID Number | Current Patient | Previous Coverage (check if yes)

Child (A)dd / (C)hange / (R)emove Last Name First Name M.I. Sex M/F Birthdate MM/DD/YYYY

Social Security Number Other Health Coverage Primary Office ID Number Current Patient Previous Coverage (check if yes)

Child (A)dd / (C)hange / (R)emove Last Name First Name M.I. Sex M/F Birthdate MM/DD/YYYY

Social Security Number Other Health Coverage Primary Office ID Number Current Patient Previous Coverage (check if yes)

Child (A)dd / (C)hange / (R)emove Last Name First Name M.I. Sex M/F Birthdate MM/DD/YYYY

Social Security Number Other Health Coverage Primary Office ID Number Current Patient Previous Coverage (check if yes)

Child (A)dd / (C)hange / (R)emove Last Name First Name M.I. Sex M/F Birthdate MM/DD/YYYY

Social Security Number Other Health Coverage Primary Office ID Number Current Patient Previous Coverage (check if yes)

Child (A)dd / (C)hange / (R)emove Last Name First Name M.I. Sex M/F Birthdate MM/DD/YYYY

Social Security Number Other Health Coverage Primary Office ID Number Current Patient Previous Coverage (check if yes)

Child (A)dd / (C)hange / (R)emove Last Name First Name M.I. Sex M/F Birthdate MM/DD/YYYY

Social Security Number Other Health Coverage Primary Office ID Number Current Patient Previous Coverage (check if yes)

E Other/Previous Insurance

Is your spouse employed? ☐ Yes ☐ No If "Yes" give name and address of your spouse's employer

Name

Address City State ZIP Code

If "Yes" to Other Health Coverage (Section D), give names & policy numbers of insurance carrier, HMO, or other source. If enrolled in Medicare Parts A and/or B identify the coverage and provide the Medicare ID #.

Name | Policy Number

If "Yes" to Other Rx Drug Coverage (Section D), give name & policy number of insurance carrier, HMO, or other source.

Name | Policy Number

If "Yes" to Previous Coverage, identify name(s) of persons, give effective date and date coverage terminated, name of previous carrier and plan number and submit a copy of the Certificate of Creditable Coverage that was issued by the previous carrier, if available.

Name | Effective Date | Date Coverage Terminated

Name of Previous Carrier | Plan Number

F Dependent Information

Does any dependent listed in Section D live at a different address than the Subscriber? ☐ Yes ☐ No If "Yes" identify the individual(s) and at what address?

Name

Address | City | State | ZIP Code

Name

Address | City | State | ZIP Code

Explain the circumstances. ______________________________

If any dependent's last name differs from yours, explain the circumstances. ______________________________

G Race/Ethnicity (Responding to this question is optional and not required)

Choose a category that most closely describes you:

☐ a. American Indian or Alaskan Native
☐ b. Asian or Pacific Islander
☐ c. Black, not of Hispanic origin
☐ d. Hispanic
☐ e. White, not of Hispanic origin

H Employee Signature - *If you have questions concerning the benefits and services provided by or excluded under this Group Master Contract contact a Member Services representative at 1-800-877-9829 before signing this form.*

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the reverse side of the employee copy of this enrollment/change request. I authorize deductions from my earnings for any required contributions.

Employee Signature – Required X ______________ Date______________ E-mail Address: ______________

I Employer Verification – To be completed by Employer

Employer Signature – Required X ______________ Title______________ Date ______________

Employee copy may be used as a temporary ID card for 30 days from the effective date if authorized by employer. Coverage must be verified with AmeriHealth prior to visiting a specialist or admission to a hospital.

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