AmeriHealth New Jersey **SEH Group Application**

Application for a small employer health benefits policy

AmeriHealth New Jersey
259 Prospect Plains Rd
Building M
Cranbury, NJ 08054

For AmeriHealth New Jersey use only
AmeriHealth Insurance Company of New Jersey | AmeriHealth HMO, Inc
Group Number: ______________________

☐ New Policy ☐ Change in Policy ☐ Requested Effective Date: ______________________

Section I: Policy holder information

1. Policyholder (full legal name of Company): ______________________

2. Tax ID Number: ______________________

3. Business Address: ______________________
   Street City State Zip

   Mailing Address: ______________________
   Street/P.O. Box # City State Zip

   Telephone: ( ) ______________________ Fax: ( ) ______________________

4. Name of Group Administrator: ______________________

5. Email Address: ______________________

6. Type of Organization: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Other (explain) ______________________

7. Nature of business: (specify) ______________________ SIC Code: ______________________

8. Number of eligible employees in your company: ______________________
   Please Refer to the New Jersey Small Employer Certification for the definition of an eligible employee.

9. Number of eligible employees to be insured: ______________________

10. Class or classes to be excluded: ______________________

11. Insurance Requested For: ☐ Employees Only ☐ Employees and Dependents
    Should the plan provide coverage for domestic partners as permitted by P.L. 2003, c. 246? ☐ Yes ☐ No
    If yes, should the plan provide coverage for children of a covered domestic partner? ☐ Yes ☐ No

12. Are you subject to the requirements of COBRA? ☐ Yes ☐ No

13. Is your employer subject to the requirements of Medicare as Secondary Payor Rules for eligibility due to age? ☐ Yes ☐ No
    Is your employer subject to the requirements of Medicare as a Secondary Payor Rules for eligibility due to disability? ☐ Yes ☐ No

14. Waiting period before employees become insured:

    Present Employees ______________________ New or Rehired Employees ______________________

15. What percentage of the premium will the employer pay? (must be a minimum of 10%) ______________________

16. Deposit: $ ______________________

17. Bancorp: ☐ Yes ☐ No
    HSA Enrollment Addendum Forms are required for each subscriber.

18. Defined Contribution Model: ☐ Yes ☐ No
    Health Plan Package Number ______________________

Premium will be due as of the effective date. The premium for the first month of coverage must be attached.

19. Affiliates, subsidiaries or branches:
Must be included for purpose of participation

Legal Name	Address	Number of eligible employees in this company	Number of eligible employees to be insured

Section II: Specifications for Coverage

HMO Portfolio

Plan Designs:
- ☐ HMO 25/50 $500/day IC
- ☐ HMO 30/50 Premium $0/day
- ☐ HMO 20/40 $1,000 deductible 70% coinsurance - Option1
- ☐ HMO 30/50 $2,500 deductible 50% coinsurance - Option3
- ☐ HMO 30/50 $1,500 deductible 70% coinsurance - Option 6

Network Options:
- ☐ Preferred
- ☐ Value

Vision Options:
- ☐ $35 Vision Biennial
- ☐ $100 Vision Biennial

Pharmacy Options:
- ☐ Formulary Rx $10/$40/$60
- ☐ Formulary Rx $10/$40/$60 with $100 Brand deductible
- ☐ Formulary Rx $10/$40/$60 with $250 Brand deductible
- ☐ $7/50%/$125 max/script Rx
- ☐ $7/50%/$125 max/script Rx with $100 Brand deductible
- ☐ $7/50%/$125 max/script Rx with $250 Brand deductible
- ☐ 50% Rx Card
- ☐ 50% Rx Card $100 Brand deductible
- ☐ 50% Rx Card $250 Brand deductible

HMO Plus Portfolio

Plan Designs:
- ☐ HMO 25/50 $500/day IC
- ☐ HMO 20/40 $1,000 deductible 70% coinsurance - Option1
- ☐ HMO 30/50 $2,500 deductible 50% coinsurance - Option3
- ☐ HMO 30/50 $1,500 deductible 70% coinsurance - Option 6

Network Options:
- ☐ Preferred
- ☐ Value

Vision Options:
- ☐ $35 Vision Biennial
- ☐ $100 Vision Biennial

Pharmacy Options:
- ☐ Formulary Rx $10/$40/$60
- ☐ Formulary Rx $10/$40/$60 with $100 Brand deductible
- ☐ Formulary Rx $10/$40/$60 with $250 Brand deductible
- ☐ $7/50%/$125 max/script Rx
- ☐ $7/50%/$125 max/script Rx with $100 Brand deductible
- ☐ $7/50%/$125 max/script Rx with $250 Brand deductible
- ☐ 50% Rx Card
- ☐ 50% Rx Card $100 Brand deductible
- ☐ 50% Rx Card $250 Brand deductible

POS Portfolio

Plan Designs:
- ☐ POS 25/50 $500/day IC; OON $2,500 deductible; 60% coinsurance
- ☐ POS 30/50 $0/day IC; OON $2,000 deductible; 60% coinsurance
- ☐ POS 30/50 $2,000 deductible; 70% coinsurance - Option 2
- ☐ POS 30/50 $1,000 deductible; 80% coinsurance - Option3

Network Options:
- ☐ Preferred
- ☐ Value

Vision Options:
- ☐ $35 Vision Biennial
- ☐ $100 Vision Biennial

Pharmacy Options:
- ☐ Formulary Rx $10/$40/$60
- ☐ Formulary Rx $10/$40/$60 with $100 Brand deductible
- ☐ Formulary Rx $10/$40/$60 with $250 Brand deductible
- ☐ $7/50%/$125 max/script Rx
- ☐ $7/50%/$125 max/script Rx with $100 Brand deductible
- ☐ $7/50%/$125 max/script Rx with $250 Brand deductible
- ☐ 50% Rx Card
- ☐ 50% Rx Card $100 Brand deductible
- ☐ 50% Rx Card $250 Brand deductible

POS Plus Portfolio

Plan Designs:
- ☐ POS Plus 25/50 $500/day IC; OON $2,500 deductible; 60% coinsurance
- ☐ POS Plus 20/40 $300/day IC; OON $1,500 deductible; 70% coinsurance
- ☐ POS Plus 30/50 $2,000 deductible; 70% coinsurance - Option 2
- ☐ POS Plus 30/50 $1,000 deductible; 80% coinsurance - Option3

Network Options:
- ☐ Preferred
- ☐ Value
- ☐ National Access Rider

Vision Options:
- ☐ $35 Vision Biennial
- ☐ $100 Vision Biennial

Pharmacy Options:
- ☐ Formulary Rx $10/$40/$60
- ☐ Formulary Rx $10/$40/$60 with $100 Brand deductible
- ☐ Formulary Rx $10/$40/$60 with $250 Brand deductible
- ☐ $7/50%/$125 max/script Rx
- ☐ $7/50%/$125 max/script Rx with $100 Brand deductible
- ☐ $7/50%/$125 max/script Rx with $250 Brand deductible
- ☐ 50% Rx Card
- ☐ 50% Rx Card $100 Brand deductible
- ☐ 50% Rx Card $250 Brand deductible

EPO Portfolio

Plan Designs:

- ☐ EPO$1,250 deductible; 80% coinsurance
- ☐ EPO $1,500 deductible; 70% coinsurance
- ☐ EPO $2, 500 deductible; 50% coinsurance
- ☐ EPO $30/50% $2,500 deductible; 50% coinsurance
- ☐ EPO $30/$50 $2,500 deductible; 80% coinsurance integrated 50% Rx
- ☐ EPO $30/$50 $2,500 deductible; 80% coinsurance National Access

Network Options:

- ☐ Preferred
- ☐ Value
- ☐ National Access Rider

Vision Options:

- ☐ $35 Vision Annual
- ☐ $100 Vision Annual
- ☐ $35 Vision Biennial
- ☐ $100 Vision Biennial
- ☐ $35 Vision, Annual Exam, Biennial Hardware
- ☐ $100 Vision, Annual Exam, Biennial Hardware

Pharmacy Options:

- ☐ Formulary Rx $10/$40/$60
- ☐ Formulary Rx $10/$40/$60 with $100 Brand deductible
- ☐ Formulary Rx $10/$40/$60 with $250 Brand deductible
- ☐ $7/50%/$125 max/scriptRx
- ☐ $7/50%/$125 max/script Rx with $100 Brand deductible
- ☐ $7/50%/$125 max/script Rx with $250 Brand deductible
- ☐ 50% Rx Card
- ☐ 50% Rx Card $100 Brand deductible
- ☐ 50% Rx Card $250 Brand deductible

EPO HSA Portfolio

Plan Designs:

- ☐ EPO HSA $1,250 deductible; 80% coinsurance

  Available with the following integrated Rx options:
  - ☐ 50%
  - ☐ 50%/$125 max/script
  - ☐ $7/50% $125 max/script
  - ☐ $10/$40/$60
- ☐ EPO HSA $1, 500 deductible; 70% coinsurance

  Available with the following integrated Rx options:
  - ☐ 50%
  - ☐ 50%/$125 max/script
  - ☐ $7/50% $125 max/script
  - ☐ $10/$40/$60
- ☐ EPO HSA $2,500 deductible; 50% coinsurance

  Available with the following integrated Rx options:
  - ☐ 50%
  - ☐ 50%/$125 max/script
  - ☐ $7/50% $125 max/script
  - ☐ $10/$40/$60

Pharmacy Options:

- ☐ Formulary Rx $10/$40/$60
- ☐ Formulary Rx $10/$40/$60 with $100 Brand deductible
- ☐ Formulary Rx $10/$40/$60 with $250 Brand deductible
- ☐ $7/50%/$125 max/script Rx
- ☐ $7/50%/$125 max/script Rx with $100 Brand deductible
- ☐ $7/50%/$125 max/script Rx with $250 Brand deductible
- ☐ 50% Rx Card
- ☐ 50% Rx Card $100 Brand deductible
- ☐ 50% Rx Card $250 Brand deductible

Network Options:

- ☐ Preferred
- ☐ Value
- ☐ National Access Rider

Non-Streamlined Plan Option: ______________________________

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Section III:

1. Is there any Group Health Plan now in force and to be continued? ☐ Yes ☐ No **If yes, identify:**
   a. Name of the Group Health Plan(s): ______________________________
   b. Description of the plan(s): ______________________________
   c. Name of insurance carrier(s): ______________________________
2. Is there any Group Health Plan currently being applied for through another carrier? ☐ Yes ☐ No **If yes, identify:**
   a. Name of the Group Health Plan(s): ______________________________
   b. Description of the plan(s): ______________________________
   c. Name of insurance carrier(s): ______________________________
3. Is the coverage being applied for in this application replacing other group insurance? ☐ Yes ☐ No
   a. If yes, explain reason: ______________________________
   b. Name of present or prior group carrier: ______________________________
   c. Plan being replaced: ______________________________
   d. Effective date: ______________________________
   e. Cancellation/Termination date: ______________________________
4. Has your firm been uninsured for 3 or more months prior to this application? ☐ Yes ☐ No

5. What forms of insurance are now, or were in force?
Please attach copies of Booklet/Certificate and most recent Billing Statement.
   ☐ Health Benefits
   ☐ Prescription Drug Benefits
   ☐ Dental Benefits
   ☐ Vision Benefits
6. To the best of your knowledge, are there any current or former employees or their eligible dependents whose health insurance is being continued?
   ☐ Yes ☐ No
   a. If yes, please provide the following information for each current/former employee or dependent on health continuations:

Name of Employee / Dependent	Date of Birth	Type of Continuation State/Federal Extended Benefits	Continuation Dates	
			Start	End

If additional space is needed, please attach a separate sheet, signed and dated.

7. To the best of your knowledge are any employees or dependents presently incapacitated? ☐ Yes ☐ No

8. To the best of your knowledge are any dependent children incapable of self-support due to a physical or mental disability? ☐ Yes ☐ No

Section IV: Agent/ Producer Information

Agent/Broker Name: ______________________________

Section V: Signature

It is understood that, except as provided under applicable regulations, 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 25 hours per week at his employer's place of business. It is further understood that no agent has power on behalf of AmeriHealth HMO, Inc. and AmeriHealth Insurance Company of New Jersey to make or modify any request or application for insurance or to bind AmeriHealth HMO, Inc. and AmeriHealth Insurance Company of New Jersey by making any promise or representation or by giving or receiving any information.

It is further understood that no insurance will be effective unless and until the application is accepted in writing by AmeriHealth HMO, Inc. and/or AmeriHealth Insurance Company of New Jersey. Final rates will be based on enrollment data as of the policy effective date. No contract of insurance is to be implied in any way on the basis of the completion and/or submission of this application.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Dated at ______________________________ on ______________________________

______________________________ ______________________________
Print name of Officer, Partner, or Proprietor Signature of Officer, Partner, or Proprietor

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Witness to Signature

Note: If there are any modifications to the statement and answers given in this application (i.e. crossed out, whited-out, erased, etc.), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.