AmeriHealth NEW JERSEY

Please Mail To:
AmeriHealth Insurance Company
P.O. BOX 41574
Philidelphia, PA 19101-1574

Instructions for completing the HINT application and verification of requirements form

Initial requests for coverage will require completion of both the HINT application and the verification of requirements form. An updated verification will be required annually, but if there is no break in coverage, only the verification will be required in subsequent years.

To qualify for coverage, the adult child must meet **all** of the eligibility criteria as either a dependent or a student:

As a dependent, the adult child must:

– must be a qualified dependent by blood or law of a covered employee/parent/subscriber;
– have a parent/subscriber who is covered under an AmeriHealth NJ plan;
– be under age 31;
– not be otherwise eligible for coverage within the plan's limiting age provisions;
– be unmarried or not entered into a civil union;
– have no dependent of his/her own;
– have proof of prior creditable coverage;
– be a resident of the State of New Jersey.

As a student, the adult child must in addition to above:

– be enrolled as a full-time student at an accredited public or private institution of higher education (Note: Although the parent/subscriber must be covered under an AmeriHealth NJ plan, the student need not reside in New Jersey);
– not receive coverage as a named subscriber, insured, enrollee or covered person under any other group health benefits plan or be entitled to benefits under Title XVIII of the Social Security Act, Pub.L. 89-97.

If the dependent is a full-time student residing out of state, the member must provide:

– the name of the school _____ ;
– the expected date of graduation _____ (mm/yyyy);
– a copy of the class schedule signed and stamped by the registrar.

In addition, please note the following:

– If the over-age dependent has not yet aged-out of his or her parent's group health benefits plan, he or she will have an opportunity to make the election within 30 days BEFORE he or she is scheduled to age-out of the coverage. If the over-age dependent has aged-out, he or she can make an election at any time, only if all the requirements are met.

– Please sign and date the application and verification. Failure to do so will delay processing of your application and coverage will not be activated during such time. Please be sure all questions have been answered, or we will not be able to process your application.

– For each eligible over-age dependent, the AmeriHealth premium rate* will be calculated at 67.4% of the single rate for the same plan of benefits in which the parent is actively enrolled. Please contact your AmeriHealth Marketing Representative for the exact over-age dependent rate. An over-age dependent must include a check for this amount when he or she mails in the completed HINT application. AmeriHealth will bill the over-age dependent directly. Ongoing premium payment must be received within 30 days of the due date, or coverage will automatically be terminated.

Note: Although the parent must continue eligibility under the AmeriHealth plan for a dependent's coverage to continue, coverage for the dependent will be issued as stand-alone coverage. All cost-sharing requirements and limitations will apply to the dependent only and will not be combined with the parent's policy. Covered expenses incurred by the dependent will not contribute to family deductibles and/or out-of-pocket maximums.

*This premium rate includes the 102% factor that is noted on the HINT application.

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Verification of requirements

The AmeriHealth contract states that a dependent may be covered to age 31 if he or she meets certain criteria:

– the dependent's parent remains covered by the plan;
– the employer retains coverage with AmeriHealth;
– contributions are made by or on behalf of the dependent.

To request continued coverage, a verification of requirements form must be completed indicating that all of the criteria have been met.

For each eligible over-age dependent, the AmeriHealth premium rate* will be calculated at 67.4% of the single rate for the same plan of benefits in which the parent is actively enrolled. Please contact your AmeriHealth Marketing Representative for the exact rate for over-age dependents. An over-age dependent must include a check for this amount when he or she mails in the completed HINT application. AmeriHealth will bill the over-age dependent directly. Ongoing premium payment must be received within 30 days of the due date or, coverage will automatically be terminated.

Note: Although the parent must continue eligibility under the AmeriHealth plan for coverage of the dependent to continue, coverage for the dependent will be issued as stand-alone coverage. This means that all cost-sharing requirements and limitations will apply to the dependent only and will not be combined with the parent's policy. Covered expenses incurred by the dependent will not contribute to family deductibles and out-of-pocket maximums, nor will family-incurred expenses contribute to dependent's deductibles or out-of-pocket maximums.

If the dependent meets the qualifications outlined in this verification, please complete, sign and return it within 30 days of your receipt along with a HINT application. A separate HINT application and verification of requirements form must be completed for each dependent.

Covered parent/Subscriber name: _____ Identifier number: _____
Dependent name : _____ Dependent SSN: _____
Group number: _____ Date of birth: _____ (mm/dd/yyyy) Phone number: _____
I, the dependent listed above: (please check all that apply):

☐ am under age 31
☐ am unmarried or not entered into a civil union
☐ have no dependent of my own
☐ have proof of prior creditable coverage
☐ am a resident of the State of New Jersey

or

☐ am a resident of the State of New Jersey, but am enrolled as a full-time student at an accredited public or private institution of higher education.
  – Name of the school _____
  – Expected date of graduation _____ (mm/yyyy)
    Please provide a copy of the class schedule signed and stamped by the registrar.
☐ am not provided coverage as a named subscriber, insured, enrollee or covered person under any other group health benefits plan, nor am I entitled to benefits under Title XVIII of the Social Security Act, Pub.L. 89-97.

By signing below, I confirm that the information I have provided is true, accurate, and current.

Signature of dependent: _____ Date:_____

Please mail this completed form to the following address within 30 days of receipt:
Mail form and first month's premium check to:
AmeriHealth New Jersey, Attn: Sales-OAD, 259 Prospect Plains Road, Bldg. M, Cranbury, NJ 08512

PLEASE DO NOT SEND THIS FORM TO ENROLLMENT.

*The premium rate includes the 102% factor that is noted on the HINT application.

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HINT Supplemental Enrollment Information Form Implementing

A. GROUP & EMPLOYEE INFORMATION

Group Name:

Group Number:

Employee Name:

Employee ID Number:

2. Date dependent was last treated:_____

B. TYPE OF ACTIVITY (SEE IMPORTANT EXPLANATORY INFORMATION BELOW)

Date of Event Change – Check all that apply

☐ Add dependent over the limiting age, but less than 31 ____/____/____

☐ Remove dependent over the limiting age, but less than 31 ____/____/____

Reason(s):_____

_____

_____

☐ Continuation of Coverage pursuant to the Dependent Under 31 Law

Coverage is being effected:

☐ Within 30 days prior to attainment of limiting age

☐ During continuous open enrollment with proof of prior creditable coverage or receipt of benefits (see C. below)

Billing:

☐ Employee payroll deduction (w/ employer consent)

☐ Direct bill dependent (add billing address):_____

C. OVER-AGE DEPENDENT INFORMATION

Name (last, first, MI):	Sex: ☐ M ☐ F	Birthdate: (MM, DD, YY)____/____/____	SSN:
Other Health Coverage: ☐ Yes ☐ No	Primary Ofc NPI#:		
Primary Ofc Address [or LOC #]:		Current Patient: ☐ Yes ☐ No	
Other Rx Drug Coverage: ☐ Yes ☐ No	Ob/Gyn Ofc NPI#:		
Ob/Gyn Ofc Address [or LOC#]:		Current Patient: ☐ Yes ☐ No ☐ N/A	

Previous Coverage: ☐ Yes ☐ No

If yes, provide the following information AND submit a copy of the certificate of Creditable Coverage that was issued by the previous carrier, if available, OR other evidence of receipt of benefits:

Effective date of prior coverage: ____/____/____

Termination date of prior coverage: ____/____/____

Name of carrier, self-funded employer/employee organization or government program:_____

Prior plan number or ID number: _____

D. SIGNATURE

Employee:	Dependent
Date:	Date:
Employer Consent to Payroll Deduction: ☐ Yes ☐ No	
Name & Title:	Date:

IMPORTANT INFORMATION FOR THE DEPENDENT UNDER 31 ELECTION

A young adult may request to continue or newly enroll as an over-age dependent on his or her parent's coverage after reaching the limiting age under the terms of the policy if the young adult:

- ✔ is not yet 31 years old;
- ✔ is unmarried;
- ✔ has no children;
- ✔ lives in New Jersey or, if not a New Jersey resident, is a full-time student at an accredited institution of higher education;
- ✔ is not eligible for Medicare and would not actually be covered under another group or individual health plan when coverage would become effective; and
- ✔ has proof of prior creditable coverage or receipt of benefits.

A young adult may make the request to continue or newly enroll as an over-age dependent on his or her parent's coverage either:

- ✔ within 30 days prior to reaching the limiting age, if the young adult is covered under the parent's policy already; or
- ✔ at any time after reaching the limiting age of the parent's policy, and otherwise meeting the eligibility requirements for the Dependent Under 31 election.

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