AmeriHealth New Jersey **SEH Group Application**

Application for a small group employer health benefits policy

APPLY

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

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. Main Address
   Street:_____
   City:_____ State:_____ Zip Code:_____
   Mailing Address
   Street:_____
   City:_____ State:_____ Zip Code:_____
   Telephone: (_____)_____ Fax: (_____)_____
   Name of Group Administrator: _____ Email Address: _____

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

5. Nature of business: (specify) | SIC Code:

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

7. Number of eligible employees to be insured:

8. Class or classes to be excluded:

9. Insurance Requested For: ☐ Employees Only ☐ Employees and Dependents including Spouse ☐ Employees and Dependents excluding Spouse
   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

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

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

12. Waiting period before employees become insured (may not exceed 90 days):
    Present Employees:_____ New or Rehired Employees:_____

13. Period for Annual Employee Open Enrollment:

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

15. Deposit: $_____ Premium Paid: ☐ Monthly ☐ Automatic check withdrawal
    Premium will be due as of the effective date. The premium for the first month of coverage must be attached.

16. 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

Platinum Portfolio

	AVAILABLE ON SHOP	OFF SHOP
☐	✔	Standard National Access Platinum POS Plus $15 Copay, $0 Ded INN
☐		Standard National Access Platinum POS Plus $20 Copay, $0 Ded INN
☐		Standard Regional Preferred Platinum POS Plus $20 Copay, $0 Ded INN
☐		Standard Local Value Platinum POS Plus $20 Copay, $0 Ded INN
☐		Standard National Access Platinum EPO $15 Copay, $0 Ded
☐		Standard Regional Preferred Platinum EPO $15 Copay, $0 Ded
☐		Standard Local Value Platinum EPO $15 Copay, $0 Ded
☐		Standard Regional Preferred Platinum HMO $15 Copay, $3250 OOP
☐		Standard Local Value Platinum HMO $15 Copay, $3250 OOP
☐		Standard Regional Preferred Platinum HMO $15 Copay $5000 OOP
☐		Standard Local Value Platinum HMO $15 Copay $5000 OOP

Gold Portfolio

	AVAILABLE ON SHOP	OFF SHOP
☐	✔	Premium National Access Gold POS Plus $30 Copay, $1000 Ded INN
☐		Premium Regional Preferred Gold POS $30 Copay, $0 Ded INN
☐		Premium Local Value Gold POS $30 Copay, $0 Ded INN
☐		Premium Regional Preferred Gold HMO $25 Copay/50%-$125 Max Rx
☐		Premium Local Value Gold HMO $25 Copay/50%-$125 Max Rx
☐		Premium Regional Preferred Gold HMO Plus $25 Copay/50%-$125 Max Rx
☐		Premium Local Value Gold HMO Plus $25 Copay/50%-$125 Max Rx
☐		Premium Regional Preferred Gold HMO $25 Copay/50% Rx
☐		Premium Local Value Gold HMO $25 Copay/50% Rx
☐		Premium Regional Preferred Gold HMO $30 Copay/$7-50%-$125 Max Rx
☐		Premium Local Value Gold HMO $30 Copay/$7-50%-$125 Max Rx
☐		Select Regional Preferred Gold HMO Plus Coinsurance $30 Copay, $1500 Ded
☐		Select Local Value Gold HMO Plus Coinsurance $30 Copay, $1500 Ded
☐		Select National Access Gold EPO $25 Copay, $500 Ded
☐		Select Regional Preferred Gold EPO $25 Copay, $500 Ded
☐		Select Local Value Gold EPO $25 Copay, $500 Ded
☐		Standard National Access Gold POS Plus $30 Copay, $1500 Ded INN
☐		Standard Regional Preferred Gold POS Plus $30 Copay, $1500 Ded INN
☐		Standard Local Value Gold POS Plus $30 Copay, $1500 Ded INN
☐	✔	Standard Regional Preferred Gold EPO $30 Copay, $1000 Ded
☐	✔	Standard Local Value Gold HMO Coinsurance $15 Copay, $2000 Ded
☐		Standard Local Value Gold EPO $15 Copay, $2000 Ded
☐	✔	Standard Local Value Gold EPO H.S.A. $1250 Ded, 20% Coins

Silver Portfolio

	AVAILABLE ON SHOP	OFF SHOP
☐	✔	Premium National Access Silver POS Plus $40 Copay, $2000 Ded
☐		Premium National Access Silver POS Plus $50 Copay, $2000 Ded INN
☐		Premium Regional Preferred Silver POS Plus $50 Copay, $2000 Ded INN
☐		Premium Local Value Silver POS Plus $50 Copay, $2000 Ded INN
☐		Premium National Access Silver EPO $1500 Ded, 30% Coins
☐		Premium Regional Preferred Silver EPO $1500 Ded, 30% Coins
☐		Premium Local Value Silver EPO $1500 Ded, 30% Coins
☐	✔	Premium Regional Preferred Silver EPO $50 Copay, $2000 Ded
☐	✔	Select Local Value Silver HMO Coinsurance $50 Copay, $2000 Ded
☐	✔	Standard Local Value Silver EPO H.S.A. $50 Copay, $1800 Ded
☐		Standard National Access Silver EPO $2000 Ded, 50% Coins
☐		Standard Regional Preferred Silver EPO $2000 Ded, 50% Coins
☐		Standard Local Value Silver EPO $2000 Ded, 50% Coins
☐	✔	Cooper Advantage Silver EPO $15 Copay, $2000 Ded
☐	✔	Tier 1 Advantage Silver EPO H.S.A. $50 Copay, $1350 Ded

Bronze Portfolio

	AVAILABLE ON SHOP	OFF SHOP
☐	✔	Premium National Access Bronze EPO H.S.A. $2350 Ded, 50% Coins
☐	✔	Premium Regional Preferred Bronze EPO H.S.A. $2350 Ded, 50% Coins
☐	✔	Premium Local Value Bronze EPO H.S.A. $2350 Ded, 50% Coins
☐	✔	Tier 1 Advantage Bronze EPO H.S.A. $50 Copay, $2350 Ded

Are you applying for the SHOP tax credit? ☐ Yes ☐ No

AmeriHealth New Jersey SEH Ancillary Riders

Adult Vision

☐	$100 allowance
☐	$150 allowance
☐	$180 allowance

AmeriHealth Smiles for Health Dental Plan

AmeriHealth Smiles for Health Dental Plan
☐ Accept ☐ Waive

In order to be compliant with the health care reform law, you must have pediatric dental coverage. To help you meet this requirement AmeriHealth New Jersey is offering Pediatric Dental Coverage through the **Smile for Health** Family Dental plan underwritten by United Concordia. If you have already purchased group coverage that includes pediatric dental with another carrier, you must provide a form of proof along with a signed attestation form. Doing so will help provide evidence of your dental coverage and compliance with federal regulations.

Section III: All questions must be answered

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):_____

   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):_____

2. Name of present or prior group carrier: _____
   a. Effective date of prior coverage: ____/____/____
   b. Cancellation/Termination date: ____/____/____
   c. Is the coverage applied for in this application replacing other group insurance? ☐ Yes ☐ No
   d. If yes, explain reason: _____

3. Are extended benefits provided in case of termination of health benefits? ☐ Yes ☐ No

4. 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	Reason for Termination Disability/Other	Continuation Dates	
				Start	End

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

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

6. Does the employer participate in an arrangement with a Professional Employer Organization? ☐ Yes ☐ No
   Refer to Advisory Bulletin 00-SEH-02 if you need information concerning what constitutes a Professional Employer Organization.

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.

☐ Please read this statement and check to confirm. I confirm that I have received the Summary of Benefits and Coverage (SBC) documents associated with the plan or plans I selected on this application. I confirm I will provide SBCs to plan participants and beneficiaries as required by federal regulations and guidance related to the distribution of the SBC, including the requiring for timing and delivery.

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:	Dated on:
Print name of Officer, Partner, or Proprietor:	Signature of Officer, Partner, or Proprietor:
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.

AmeriHealth NEW JERSEY