


AmeriHealth New Jersey Application for Small Group Member Coverage

APPLY

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

		Group Information – to be completed by Employer:				
AmeriHealth New Jersey		Group Name:	Group Number:	Class Code:		
A. Type of Activity – To be completed by Applicant. <i>Refer to instructions before completing this form. Print clearly.</i>						
	Activity – Check all that apply	Date of Event	Date of Hire/Reason for Change			
ADD	<input type="checkbox"/> Enrollment of a new Subscriber	____/____/____	Date: ____/____/____	Reason: _____		
	<input type="checkbox"/> Add Spouse	____/____/____	Date: ____/____/____	Reason: _____		
	<input type="checkbox"/> Add Civil Union Partner	____/____/____	Date: ____/____/____	Reason: _____		
	<input type="checkbox"/> Add Domestic Partner	____/____/____	Date: ____/____/____	Reason: _____		
	<input type="checkbox"/> Add Dependent Child	____/____/____	Date: ____/____/____	Reason: _____		
	<input type="checkbox"/> Add Over-Age Child as a Dependent Under 31 <i>(and complete Coverage Continuation section)</i>	____/____/____	Date: ____/____/____	Reason: _____		
REMOVE	<input type="checkbox"/> Employee Withdrawal/Termination	____/____/____	Date: ____/____/____	Reason: _____		
	<input type="checkbox"/> Remove Spouse	____/____/____	Date: ____/____/____	Reason: _____		
	<input type="checkbox"/> Civil Union Partner	____/____/____	Date: ____/____/____	Reason: _____		
	<input type="checkbox"/> Remove Domestic Partner	____/____/____	Date: ____/____/____	Reason: _____		
	<input type="checkbox"/> Remove Dependent Child	____/____/____	Date: ____/____/____	Reason: _____		
	<input type="checkbox"/> Remove Over-Age Child as a Dependent Under 31	____/____/____	Date: ____/____/____	Reason: _____		
OTHER CHANGES	<input type="checkbox"/> Name Change	____/____/____	_____			
	<input type="checkbox"/> Change Plan	____/____/____	_____			
	<input type="checkbox"/> Other	____/____/____	_____			
	<input type="checkbox"/> Add/Change Office ID Numbers: Primary/OB/Gyn/Dentist <i>* See list of Triggering Events in Instructions</i>	____/____/____	_____			
COVERAGE CONTINUATION	<input type="checkbox"/> For Employee	<input type="checkbox"/> Total Disability* <input type="checkbox"/> COBRA/NJSGC	Length of Continuation (in months): <input type="checkbox"/> 18 <input type="checkbox"/> 29	Date of Loss of Coverage: ____/____/____	Qualifying Event #: _____**	Date of Qualifying Event: ____/____/____
	Billing: <input type="checkbox"/> Group <input type="checkbox"/> Home (Section B)					*Attach proof of disability
	<input type="checkbox"/> For Spouse/Civil Union Partner*	Length of Continuation (in months): <input type="checkbox"/> 18 <input type="checkbox"/> 36	Date of Loss of Coverage: ____/____/____	Qualifying Event #: _____**	Date of Qualifying Event: ____/____/____	
	Billing: <input type="checkbox"/> Group <input type="checkbox"/> Home (what address?) <input type="checkbox"/> Section B OR <input type="checkbox"/> Section E			*Civil union partners are eligible to make an election pursuant to NJSGC, if applicable.		
	<input type="checkbox"/> For Dependent/Over-age Child	<input type="checkbox"/> COBRA/NJSGC	Length of Continuation (in months): <input type="checkbox"/> 18 <input type="checkbox"/> 36	Date of Loss of Coverage: ____/____/____	Qualifying Event #: _____**	Date of Qualifying Event: ____/____/____
	<input type="checkbox"/> Dependent Under 31	Qualifying Event #: _____**	Billing: <input type="checkbox"/> Group <input type="checkbox"/> Home (what address?) <input type="checkbox"/> Section B OR <input type="checkbox"/> Section E			
	Qualifying event #s: see list in Instructions. *Billing through the group for a Dependent Under 31 Continuation Election requires agreement by the employer at Section J.					
B. Employee Information – To be completed by the Employee						
Name (Last, First, MI):		SSN:	Birthdate (mm/dd/yyyy)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F		
HOME	Street/Apt: _____					
	Street/Apt: _____					
	City, State, Zip Code: _____					
	Phone: _____ Email: _____					
WORK	[Employer] Name: _____					
	Address: _____					
	City, State, Zip Code: _____					
	Phone: _____ Email: _____					
Employment Date: _____ Hours worked per week: _____						

ACTIVITY	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continuation <input type="checkbox"/> Other Change – <i>If a name change, indicate prior name:</i>		
	Primary Loc #:	NPI or PCP ID #:	Current Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Address:		
	Ob/Gyn Loc #:	NPI or PCP ID #:	Current Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Address:		
	Dentist Loc #:	NPI or PCP ID #:	Current Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No
Address:			

Other Health Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Payer Name: _____ Policy #: _____ Medicare ID#, if any: _____	Other Rx Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Payer Name: _____ Policy #: _____ Medicare ID#, if any: _____
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C. Plan Option – to be completed by the Employee	Plan Name: _____
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D. Other Individuals Covered – to be completed by the Employee *Identify individuals other than yourself for whom you are adding/changing removing coverage. Attach additional pages if necessary, dated and signed by you. Attach proof of disability if necessary.*

1. Spouse/Domestic Partner/ Civil Union Partner	2. Child	3. Child	4. Child
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Other <input type="checkbox"/> Continue Spouse <input type="checkbox"/> Continue CU Partner (NJSGC)	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Other <input type="checkbox"/> Continue	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Other <input type="checkbox"/> Continue	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Other <input type="checkbox"/> Continue
Name (last, first, MI) L: _____ F: _____ MI: _____	Name (last, first, MI) L: _____ F: _____ MI: _____	Name (last, first, MI) L: _____ F: _____ MI: _____	Name (last, first, MI) L: _____ F: _____ MI: _____
Birthdate (mm/dd/yyyy): ____ / ____ / ____	Birthdate (mm/dd/yyyy): ____ / ____ / ____	Birthdate (mm/dd/yyyy): ____ / ____ / ____	Birthdate (mm/dd/yyyy): ____ / ____ / ____
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security Number: _____	Social Security Number: _____	Social Security Number: _____	Social Security Number: _____
Other health coverage <input type="checkbox"/> No <input type="checkbox"/> Yes – If Yes: Payer Name: _____ Policy #: _____ Medicare ID #: _____	Other health coverage <input type="checkbox"/> No <input type="checkbox"/> Yes – If Yes: Payer Name: _____ Policy #: _____ Medicare ID #: _____	Other health coverage <input type="checkbox"/> No <input type="checkbox"/> Yes – If Yes: Payer Name: _____ Policy #: _____ Medicare ID #: _____	Other health coverage <input type="checkbox"/> No <input type="checkbox"/> Yes – If Yes: Payer Name: _____ Policy #: _____ Medicare ID #: _____
Other Rx Coverage: <input type="checkbox"/> No <input type="checkbox"/> Yes – If Yes: Payer Name: _____ Policy #: _____ Medicare ID #: _____	Other Rx Coverage: <input type="checkbox"/> No <input type="checkbox"/> Yes – If Yes: Payer Name: _____ Policy #: _____ Medicare ID #: _____	Other Rx Coverage: <input type="checkbox"/> No <input type="checkbox"/> Yes – If Yes: Payer Name: _____ Policy #: _____ Medicare ID #: _____	Other Rx Coverage: <input type="checkbox"/> No <input type="checkbox"/> Yes – If Yes: Payer Name: _____ Policy #: _____ Medicare ID #: _____
Primary Care Provider: NPI or PCP ID #: _____ Address: _____ _____ _____ Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Primary Care Provider: NPI or PCP ID #: _____ Address: _____ _____ _____ Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Primary Care Provider: NPI or PCP ID #: _____ Address: _____ _____ _____ Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Primary Care Provider: NPI or PCP ID #: _____ Address: _____ _____ _____ Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Ob/Gyn Office NPI or PCP ID #: _____ Address: _____ _____ _____ Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Ob/Gyn Office NPI or PCP ID #: _____ Address: _____ _____ _____ Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Ob/Gyn Office NPI or PCP ID #: _____ Address: _____ _____ _____ Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Ob/Gyn Office NPI or PCP ID #: _____ Address: _____ _____ _____ Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA

Dentist Office NPI or PCP ID #: _____ Address: _____ _____ Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Dentist Office NPI or PCP ID #: _____ Address: _____ _____ Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Dentist Office NPI or PCP ID #: _____ Address: _____ _____ Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Dentist Office NPI or PCP ID #: _____ Address: _____ _____ Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, complete Section E1</i>	If last name is different from Employee's, please explain: _____ _____	If last name is different from Employee's, please explain: _____ _____	If last name is different from Employee's, please explain: _____ _____
Home or billing address same as Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If NO, complete Section E2</i>	Living with Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If NO, complete Section F</i>	Living with Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If NO, complete Section F</i>	Living with Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If NO, complete Section F</i>

E. Additional Spouse/Civil Union Partner/Domestic Partner Information – to be completed by Employee *If not applicable, please mark as "NA."*

1.	Employer Name: _____ Employer Address: _____ City, State, Zip Code: _____ Phone: _____
2.a	Street/Apt: _____ Street/Apt: _____ City, State, Zip Code: _____
2.b	Please explain why the address is different: _____ _____

F. Additional Child Information – to be completed by Employee *Provide information below about children listed in Section D, if they have a different address from the employee. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.*

Name(s): _____ Street/Apt: _____ Street/Apt: _____ City, State, Zip Code: _____ Reason: _____	Name(s): _____ Street/Apt: _____ Street/Apt: _____ City, State, Zip Code: _____ Reason: _____
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G. Race/Ethnicity – to be completed by Employee at his/her option. *NOTE: your response is appreciated but NOT required!*

Choose a category that most closely describes you:
 American Indian or Alaskan Native
 Black, not of Hispanic origin
 Hispanic
 Asian or Pacific Islander
 White, not of Hispanic origin

H. Employee Signature

I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I authorize deductions from my earnings for any contributions required from me.

Signature: _____ Date: ____/____/____

I. Over-Age Child's Signature

I represent that all the information supplied in this application regarding the Dependent Under 31 Continuation Election is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I hereby agree to make contributions required from me for the Dependent Under 31 Continuation Election.

Signature: _____ Date: ____/____/____

J. Employer Verification

The requested activity is believed eligible and is approved by the Employer. In addition, the Employer consents to payroll deduction for Dependent Under 31 Continuation Election: Yes No

Employer Representative: _____ Date: ____/____/____

Representative's Title: _____

INSTRUCTIONS

Employers – You must complete the Employer Group Information and sections A and J in order for this application to be processed.

Employees – You must complete sections B through H and submit the signature of each Over-Age Child for which a Dependent Under 31 Continuation Election is made in accordance with Section I in order for this application to be processed.

- Please PRINT except when a signature is requested provide further requested information.
- If a dependent is disabled and you want to continue his or her coverage beyond age 26, you do not have to make a COBRA/NJSGC or Dependent Under 31 election. Instead, select "Other" in Section A3, and attach proof of disability. If a dependent child is disabled and you want to continue his or her coverage beyond age 26, describe this in "Other Change" in Section A, and attach proof of disability.
- For provider addresses, include the zip code plus the four digit extension (9 digits)
- You can obtain the providers' correct names and addresses from the appropriate provider directory. You may also obtain each provider's NPI or PCP ID number from www.amerihhealth.com. Providers with multiple office locations and individual providers who belong to more than one practice or provider entity may have more than one NPI or PCP ID number. You should confirm the correct NPI or PCP ID number for the specific provider and office location where you will be seen by contacting that office directly.

Triggering Events

COBRA and NJSGC

- C1. Termination of job or reduction in hours
- C2. Employee enrollment in Medicare (COBRA only)
- C3. Divorce (COBRA/NJSGC); civil union dissolution (NJSGC)
- C4. Death of employee
- C5. Loss of dependent child status under the plan
- C6. Disability (occurring subsequent to another qualifying event)

Dependent Under 31

- D1. Loss of dependent status and otherwise eligible
- D2. Reestablish eligibility: residency
- D3. Reestablish eligibility: nonresident full-time student
- D4. Reestablish eligibility: change in marital status
- D5. Reestablish eligibility: change in parental status
- D6. Reestablish eligibility: termination of other coverage

CONDITIONS OF ENROLLMENT – APPLICANT ACKNOWLEDGEMENTS AND AGREEMENTS

On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer reporting agency, and any employer to give AmeriHealth New Jersey, or any consumer reporting agency acting on behalf of AmeriHealth New Jersey, information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that AmeriHealth New Jersey has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one.
4. I agree AmeriHealth New Jersey will provide coverage in accordance with the terms of the contract for the individual plan.
5. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the individual plan if premiums are not paid timely.

MISREPRESENTATIONS

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

IMPORTANT: The Patient Protection and Affordable Care Act (PPACA) requires that you have pediatric dental coverage. To help you meet that requirement we have pre-selected our Smile for Health Family C40A50 dental plan which provides coverage for you and any eligible family members including pediatric dental coverage as required by PPACA. If you do not select the Smile for Health Family C40A50 dental plan, you will need to provide proof of coverage in another Pediatric Dental plan to ensure that you meet the Federal requirements under PPACA.

