Instructions for Completing the Application for Dental Care Individual Coverage

1. This Application should be used if you wish to enroll in a standalone Dental plan purchased directly from AmeriHealth. The dental plans available through this Application are not eligible for federal premium tax credits or cost sharing reductions available under the health care law.
2. Please complete all sections and print clearly in black ink.
3. Read carefully and sign the enclosed ***Declarations and Conditions of Enrollment***.
4. Provide information about your spouse, domestic partner, and dependents, if they are also applying for coverage. If you need additional space, attach a separate sheet with your signature and date.
5. Select one of the following payment options for your Dental plan.

   FIRST PAYMENT:

   - Credit/debit and prepaid debit cards are accepted for the first month's premium. You can:
   - Pay by phone by calling 1-800-313-9168 (TTY: 771)
   - Or, visit amerihealth.com/paymentoptions for instructions on how to pay online through e-Bill. If you would rather make your first payment by check, mail it along with this application to the address on the form.

   ONGOING PAYMENTS:

   For instructions on how to set up ongoing payments, visit amerihealth.com/paymentoptions or call 1-844-937-2448 (TTY: 711).

   Important: Receipt of your initial payment does not constitute enrollment in this program. Your coverage will not begin until this application has been processed, an effective date assigned, and your payment is applied to your account. Failure to provide all information requested may result in a delay in the processing of your application. If we are unable to process your application, your check will be returned by mail.

6. Once your materials are complete, be sure to make a copy for your records. Mail your application to:

   AmeriHealth
   PO Box 8240
   Philadelphia, PA 19101-9250

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AmeriHealth

Application for Dental Care Individual Coverage

Please mail to:
AmeriHealth
PO Box 8240
Philadelphia, PA 19101-9250

The Dental Individual Coverage is underwritten by AmeriHealth Insurance Company.

In order to be eligible for coverage, the following must be true:

- The primary applicant must be 19 or older.
- Applicants must be a New Jersey resident (Your primary residence is in New Jersey.)
- After initial enrollment, dependents can be added or removed mid-year, only with a qualifying Triggering Event. If there is no qualifying Triggering Event, dependents can only be added or removed on renewal.

A. Type of Activity

Reason for Application – Check all that apply		Date of event	Reason
Add/ New Enrollment	☐ Enrollment of a new Subscriber		
	☐ Add Spouse		
	☐ Add Civil Union Partner		
	☐ Add Domestic Partner		
	☐ Add Dependent Child(ren)		
Remove	☐ Remove Subscriber		
	☐ Remove Spouse		
	☐ Remove Civil Union Partner		
	☐ Remove Domestic Partner		
	☐ Remove Dependent Child(ren)		
Other Changes	☐ Name change		
	☐ Change plan		
	☐ Special Enrollment Period (due to a Triggering Event*)		
	☐ Other		

B. Subscriber Information — Primary applicant information (must be 19 or older)

Primary applicant name (last, first, MI)	SSN	Birthdate (mm/dd/yyyy)
Email		
By providing an email address, you consent to receive information, including the policy, by electronic means.		

☐ Male ☐ Female	Are you a resident of New Jersey? ☐ Yes ☐ No	Do you maintain a home in any other state or country? ☐ Yes ☐ No
		If yes to the above, name of state/country
		Number of months you live there each year

Address Information		
	Primary Residence	
	Street/Apt	
	Street/Apt	City
	State	ZIP code
	Other Residence	
	Street/Apt	
	Street/Apt	City
	State	ZIP code
	Your billing address ☐ Primary residence ☐ Other residence ☐ P.O. Box or other (*specify*) Mailing address for communications other than bills ☐ Primary residence ☐ Other residence ☐ P.O. Box or other (*specify*)	

* See list of Triggering Events in instructions. Provide evidence of Triggering Event with the enrollment form.

Application for Dental Care Individual Coverage

C. Choice of Plan — To be completed by Subscriber. *Refer to instructions before completing this form. Print clearly.*

Pediatric dental options
Required:

☐	IHC Pediatric Dental
☐	IHC Pediatric Dental with Adult Preventive
☐	IHC Family Plus Dental
☐	Attest to pediatric dental coverage elsewhere

IMPORTANT: The Patient Protection and Affordable Care Act (PPACA) requires that you have pediatric dental coverage for any eligible family members younger than 19. The above AmeriHealth's dental plan options satisfy this requirement.

Non-ACA Compliant — These plans do not meet the Patient Protection Care Act (PPACA)

☐	AH - Family Dental PPO 100/50/30/0 $1000
☐	AH - Family Active Dental PPO 100/80/50/50 $1500

Do you currently have dental coverage? ☐ Yes ☐ No

If yes, please provide the following:

Dental Carrier's Name	Dental Policy Number

D. Other Individuals Covered — *Identify individuals for whom you are adding/changing/removing coverage.*
(Note: If the action applies to the Subscriber, include the information in Section B.)
Attach additional pages if necessary, dated and signed by you. Attach proof of disability.

1. Spouse/Domestic Partner/ Civil Union Partner	2. Child	3. Child	4. Child
☐ Add ☐ Remove ☐ Other	☐ Add ☐ Remove ☐ Other	☐ Add ☐ Remove ☐ Other	☐ Add ☐ Remove ☐ Other
Name (last, first, MI)	**Name (last, first, MI)**	**Name (last, first, MI)**	**Name (last, first, MI)**
Last	Last	Last	Last
First	First	First	First
MI	MI	MI	MI
Birthdate (mm/dd/yyyy)	Birthdate (mm/dd/yyyy)	Birthdate (mm/dd/yyyy)	Birthdate (mm/dd/yyyy)
Age	Age	Age	Age
☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
SSN	SSN	SSN	SSN
If last name is different from Subscriber, please explain	If last name is different from Subscriber, please explain	If last name is different from Subscriber, please explain	If last name is different from Subscriber, please explain
Home address same as Subscriber? ☐ Yes ☐ No *If NO, complete Section E*	Home address same as Subscriber? ☐ Yes ☐ No *If NO, complete Section F*	Home address same as Subscriber? ☐ Yes ☐ No *If NO, complete Section F*	Home address same as Subscriber? ☐ Yes ☐ No *If NO, complete Section F*

E. Additional Spouse / Civil Union Partner / Domestic Partner Information — *If not applicable, please mark as "NA."*

Street/Apt			Please explain why the address is different
Street/Apt			
City	State	ZIP code	

F. Payment Information — *Indicate how you would like to be billed and make payment.*

☐ Check ☐ Money order ☐ Credit/Debit card (*first payment only*) ☐ Pre-paid debit card

Credit/Debit card type ☐ American Express ☐ Discover ☐ MasterCard ☐ Visa

Credit/Debit card #	Expiration date	Security code

Cardholder name

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Application for Dental Care Individual Coverage

G. Race/Ethnicity — The federal government is collecting information on race and ethnicity on covered persons. Enter a numbered code for race and ethnicity that best describes each person you are seeking to cover. You can choose up to three categories of race and two categories of ethnicity per person. Add additional pages if necessary for additional children. *Response is appreciated but NOT required!*
Choose a category that most closely describes you:

Race				Ethnicity	
1	White	11	Other Asian	1	Hispanic
2	Black or African American	12	Native Hawaiian or Other Pacific Islander	2	Not Hispanic
3	American Indian or Alaska Native	13	Native Hawaiian	3	Cuban
4	Asian	14	Guamanian or Chamorro	4	Mexican, Mexican American, Chicano/a
5	Asian Indian	15	Samoan	5	Puerto Rican
6	Chinese	16	Other Pacific Islander	6	An Ethnicity Not Listed Above
7	Filipino	17	Middle Eastern or North African	7	Unknown
8	Japanese	18	Another Race Not Listed Above	8	Decline to Respond
9	Korean	19	Unknown		
10	Vietnamese	20	Decline to Report		

Covered Person	Race Code	Race Code	Race Code	Ethnicity Code	Ethnicity Code
Applicant					
Spouse					
Child 1					
Child 2					
Child 3					

H. Declarations and Conditions of Enrollment

By applying to AmeriHealth Insurance Company ("the company") for coverage for myself and the dependents listed in Section D, I understand and agree to the following:

1. a) For your effective coverage date, please see the information in your Policy provided by AmeriHealth.
   b) Coverage does not begin until this application is processed by the company with an effective date of coverage assigned and payment has been received.
   c) Credit card/debit card payments and pre-paid debit card payments are acceptable for the first month's premium payment only.
   d) Receipt of the initial payment does not constitute enrollment under any program.
   e) This coverage is provided only to residents of the geographical area of New Jersey served by the company. The company reserves the right to investigate and confirm your residence.
2. The company may void this non-group benefit policy within three (3) years of the effective date if it is found that this non-group benefit policy was obtained or maintained by intentionally supplying a material misrepresentation of fact, except in the case of fraud, for which there is no time limit for voiding the policy.
3. The terms and conditions of the coverage will be controlled by the written agreement with the company, and the company may adopt policies, procedures, rules, and interpretations to administer benefits under the policy. It is recognized that the coverage will only apply to admissions that occur and services that are provided on or after the effective date of coverage.
4. By enrolling in this benefit program, I acknowledge that in connection with the administration of, or delivery or receipt of benefits, under the non-group policy, the company will use and disclose PHI (protected health information) for purposes of Treatment, Payment, and Operations (TPO) as this term is defined by federal law.
5. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
6. I can confirm that no one applying for health insurance on this Application is incarcerated (detained or jailed).

I. Subscriber's Signature

I acknowledge that I have read, understand all statements in this application, and have supplied the requested information.
The information supplied on the application and any signed addendum is accurate and complete to the best of my knowledge.
No material information has been withheld or omitted on any person applying.
I understand that if my signature and date do not appear and/or my answers are incomplete, the application will either be rejected or returned for completion.
I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form.

Signature	Date

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Application for Dental Care Individual Coverage

J. Statement of Accountability — *(if applicable)*	
To be completed if the applicant cannot complete or has not completed the application:	
I, _____, have read and completed the application form for the primary applicant for the following reason(s):	
☐ Applicant does not speak English	☐ Applicant does not read English
☐ Applicant does not write in English	☐ Other (please explain)
I translated and fully explained the "Declarations and Conditions of Enrollment." I also translated the contents of this form and to the best of my knowledge obtained and listed all the requested information disclosed by:	
Name	Signature of translator (required)
Date (required)	Relationship to applicant

K. Broker information — *(If applicable)*	
Agent National Producer Number (NPN)	
Primary broker code	Producer broker code
Primary broker name	Producer name
Telephone number	Telephone number

AmeriHealth Sales Representative *(if applicable)*
National Producer Number (NPN)
Name of sales representative

L. Broker / General Agent Signature		
Signature of Preparer	Date	NJ Producer License #
		NPN
General Agent		Agent ID #

M. Assistance with completing this application — *(if applicable)*		
You can choose an authorized representative. You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact AmeriHealth. If you're a legally appointed representative for someone on this application, submit proof with the application.		
Authorized Representative	*Complete all applicable fields.*	
	Full name	
	Street/Apt	
	Street/Apt	City
	State	ZIP code
	Organization name	
	Phone number	ID number
By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with AmeriHealth.		
Signature	Date	

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Application for Dental Care Individual Coverage

Instructions and Eligibility Requirements

Instructions

- Except for Section G, you must complete Sections A through I, and sign and date this form and any additional pages you may need to submit with it to provide further requested information.
- Please PRINT, except when a signature is requested.
- 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.
- If you are applying to add a Spouse, Civil Union Partner, Domestic Partner, or Child, please indicate this in Section A by checking the applicable box in the Add section and identifying the applicable Triggering Event under "Reason."
- If you have questions concerning the benefits and services provided by or excluded under this policy, call 888-968-7241 (TTY: 771) before signing this form.
- KEEP A COPY OF THIS COMPLETED APPLICATION! Coverage must be verified with AmeriHealth prior to using your benefits. You may also register for your secure member account at amerihealth.com and print a temporary ID card that is valid for 10 days.
- Triggering Events to add or remove dependents:
  Please note: You must provide evidence of the triggering event with your enrollment form.

TRIGGERING EVENT means an event that results in an individual becoming eligible for a Special Enrollment Period. Triggering Events are:

1. a) The date a Dependent child's coverage ends as a result of attaining age 26 whether or not the Dependent is eligible for continuing coverage in accordance with federal or state laws.
   b) The date an Eligible Person gains or becomes a Eligible Dependent due to adoption, placement for adoption, or placement in foster care or through a child support order or other court order; only the Eligible Person and new Eligible Dependents qualify for a Triggering Event.
   c) The date an Eligible Person and his or her dependent child(ren) who are victims of domestic abuse or spousal abandonment need to enroll for coverage apart from the perpetrator of the abuse or abandonment.

Exception: A loss of coverage resulting from nonpayment of premium, fraud or misrepresentation of material fact shall not be a Triggering Event.

1. a) For your effective coverage date, please see the information in the Premium Rate Letter.
   b) Coverage does not begin until this application is processed by the company with an effective date of coverage assigned and payment has been received.
   c) Credit card/debit card payments and pre-paid debit card payments are acceptable for the first month's premium payment only.
   d) Receipt of the initial payment does not constitute enrollment under any program.
   e) This coverage is provided only to residents of the geographical area of state of New Jersey. The company reserves the right to investigate and confirm your residence.
2. The company may void this non-group benefit policy within three (3) years of the effective date if it is found that this non-group benefit policy was obtained or maintained by intentionally supplying a material misrepresentation of fact, except in the case of fraud, for which there is no time limit for voiding the policy.
3. The terms and conditions of the coverage will be controlled by the written agreement with the company, and the company may adopt policies, procedures, rules, and interpretations to administer benefits under the policy. It is recognized that the coverage will only apply to admissions that occur and services that are provided on or after the effective date of coverage.
4. By enrolling in this benefit program, I acknowledge that in connection with the administration of, or delivery or receipt of benefits, under the non-group policy, the company will use and disclose PHI (protected health information) for purposes of Treatment, Payment, and Operations (TPO) as this term is defined by federal law.
5. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
6. I can confirm that no one applying for dental insurance on this Application is incarcerated (detained or jailed

Eligibility

A. You MUST be a New Jersey resident, which means your primary residence is in New Jersey.

AH PPO 100/50/30/0 $1000 & AH PPO 100/80/50/50 $1500 Enrollment: You may apply for Dental coverage at any time during the year. This is to certify that, in consideration of payment of all Premiums when due and receipt of an accurate and complete application information, the Company will insure the Policyholder for Dental benefits in accordance with the terms and conditions of this Policy. Coverage will begin at 12:01 AM on the Effective Date. It will remain in force until the first Renewal Date, and for such further periods for which it is renewed.

A Special Enrollment Period lasts for 60 days following the Triggering Events. The effective date of a new policy will be no later than the first of the month following receipt of the application.

IHC Pediatric Dental, IHC Pediatric Dental with Adult Preventive, IHC Family Plus Dental Enrollment: You may apply for Dental coverage during Open Enrollment or due to a SEP. This is to certify that, in consideration of payment of all Premiums when due and receipt of an accurate and complete application information, the Company will insure the Policyholder for Dental benefits in accordance with the terms and conditions of this Policy. Coverage will begin at 12:01 AM on the Effective Date. It will remain in force until the first Renewal Date, and for such further periods for which it is renewed.

A Special Enrollment Period lasts for 60 days following the Triggering Events. The effective date of a new policy will be no later than the first of the month following receipt of the application.

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Application for Dental Care Individual Coverage

Instructions and Eligibility Requirements — *(Continued)*

AH PPO 100/50/30/0 $1000 & AH PPO 100/80/50/50 $1500 Other Coverage and Enrollment Rules:

Policy effective date can be on the 1st & 15th of the month, for initial enrollment, with or without medical coverage, all year round, regardless of reason for coverage.

- Effective Date Rule: If you submit your application on or after the 16th day of the month, then your coverage will become effective on the 1st of the upcoming month. (Eg, if you join on April 28th, your coverage will be effective on May 1st.)
- Policy Changes Rules: The Policyholder can make mid-contract year changes due to qualified SEP event to add or remove dependents.
- Plan changes to upgrade or downgrade coverage are not allowed mid-plan year and can only be made upon renewal.
- Ongoing Renewals: Policies renew on the 1st of the month, regardless of their exact initial enrollment date. (Eg, if you join on April 15th your renewal will be April 1st. If you join April 30th, your renewal will still be April 1st.)

Once your policy is active, if you elect to not renew, you will not be permitted to apply for a new Dental policy with the Company for one year from your renewal date.

IHC Pediatric Dental IHC Pediatric Dental with Adult Preventive, IHC Family Plus Dental Other Coverage and Enrollment Rules:

Policy effective date can be on the 1st & 15th of the month, for initial enrollment, with or without medical coverage, all year round, regardless of reason for coverage.

- Effective Date Rule: If you submit your application on or after the 16th day of the month, then your coverage will become effective on the 1st of the upcoming month. (Eg, if you join on April 28th, your coverage will be effective on May 1st.)
- Policy Changes Rules: The Policyholder may add or remove Dependents or change benefit plans during Special Enrollment Periods. Policyholders must notify the Company within sixty (60) days
- Ongoing Renewals: Policies renew on January 1st.

Once your policy is active, if you elect to not renew, you will not be permitted to apply for a new Dental policy with the Company for one year from your renewal date.

Conditions of Enrollment — *Subscriber acknowledgments 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, other medical care institution, carrier, consumer reporting agency, or employer to give AmeriHealth, or any consumer reporting agency acting on behalf of AmeriHealth, 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 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 will provide coverage in accordance with the terms of the contract for the individual plan.
5. I understand that my enrollment and the enrollment of my listed dependents in an AmeriHealth individual plan is subject to acceptance by AmeriHealth.
6. I agree that the Dental 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 on time.

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