AmeriHealth

Instructions for Completing the Application for Adult Vision Care Individual Coverage

1. This Application should be used if you wish to enroll in a standalone Vision plan purchased directly from AmeriHealth. The vision 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 adult vision 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. There is a 30 day Waiting Period applicable to all Covered Services and Supplies.
7. Once your policy is active, if you elect to not renew, you will not be permitted to apply for a new Vision policy with the Company for one year from your renewal date.
8. 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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Application for Adult Vision Care Individual Coverage

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

The Adult Vision Individual Coverage is underwritten by AmeriHealth Insurance Company of New Jersey.
AmeriHealth vision plans are administered by Davis Vision, an independent 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.)
- Dependent children must be between 19 - 26 years old for Adult plans.
- After initial enrollment, Eligible Dependents can be added or removed mid-year, only with a qualifying Triggering Event. If there is no qualifying Triggering Event, Eligible 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 Adult Vision Care Individual Coverage

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

Standalone Adult Vision Care Plans	
☐	Adult Vision Care $100/$150
☐	Adult Vision Care $130/$180
☐	Adult Vision Care $150/$200

Type of Coverage	
☐	Individual Only
☐	Individual and spouse or domestic partner
☐	Parent and child
☐	Parent and children
☐	Family (Parents & children)

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 Adult Vision 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 ("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 includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
6. I can confirm that no one applying for health insurance on this Application is incarcerated (detained or jailed).

AmeriHealth

Application for Adult Vision Care Individual Coverage

I. 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, or employer to give 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 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 on time.

J. 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

K. 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

L. 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

M. Broker / General Agent Signature

Signature of Preparer	Date	NJ Producer License #
		NPN
General Agent		Agent ID #

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Application for Adult Vision Care Individual Coverage

N. 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

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 Eligible 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.

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Application for Adult Vision Care Individual Coverage

Instructions and Eligibility Requirements — *(Continued)*

Enrollment: You may apply for Vision 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 Vision 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 Renewal Date, and for such additional periods for which it is renewed.

A **Special Enrollment Period** means a period of time that is no less than 60 days following the date of a Triggering Event during which individuals are permitted to enroll in this plan.

Other Coverage and Enrollment Rules:

- The Policy effective date will be on the 1st & 15th of the month based on receipt of the completed application with or without medical coverage, all year round, regardless of reason for coverage.
- Effective Date - 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.)
- You may make mid-contract year changes due to a qualified Triggering Event to add or remove dependents.
- Plan changes to upgrade or downgrade your policy coverage are not allowed mid-plan year and can only be made at renewal.
- Ongoing Renewals: Policies renew on the 1st of the month each year, regardless of your initial enrollment date. (Eg, if you join on April 15th your, renewal will be April 1st.)
- Dependents can be added or removed only with a qualifying Triggering Event. The renewal date for a newly added dependent will follow the subscriber's renewal date.
- If there is no qualifying Triggering Event, dependents can only be added or removed on renewal.
- Dependents must be ages 19-26.
- Dependents that are removed due to a Triggering Event are eligible to reapply for coverage due to a subsequent Triggering event, without meeting the one-year wait for termination.
- If a dependent is removed for any reason other than a qualifying Trigger Event, the dependent is not permitted to apply for coverage for one year from your renewal date.
- The 30 day Waiting Period applies to all newly added members and dependents if there are breaks in coverage effective dates.
- There is a 30 day Waiting Period applicable to all Covered Services and Supplies.
- Once your policy is active, if you elect to not renew, you will not be permitted to apply for a new Vision policy with the Company for one year from your renewal date.

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