SEH Group Application

New business:
Fax to 215-238-2508 or 215-238-2507
Form must be sent with new business submission and tracking cover sheet.

Retention business:
Send to your AmeriHealth New Jersey Account Executive

Application for a small group health benefits policy

New Policy Change in Policy Requested Effective Date:_______________

Note: The Effective Date will be on or after the date AmeriHealth New Jersey approves the application.

Please print or type
Policy Number: _______________
For AmeriHealth New Jersey use only
AmeriHealth Insurance Company of New Jersey | AmeriHealth HMO, Inc
Group Number:_______________

Section I: Policy holder information

1. Policyholder (full legal name of Company)
2. Tax Identification Number
3. **Main Address**

Street/Apt		
Street/Apt	City	
State	Zip Code	Phone
Email Address	Facsimile	
Main Address		
Street/Apt		
Street/Apt	City	
State	Zip Code	Phone
Email Address	Facsimile	

Contract information should be provided. Check one electronically hard copy

4. Type of Organization Corporation Partnership Proprietorship Other (explain)_______________
5. Nature of business (specify) SIC Code
6. Number of full-time employees in your company_______________
   Please Refer to the New Jersey Small Employer Certification for the definition of a full-time employee.
7. Number of full-time 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 coverage of children of a covered domestic partner? Yes No
10. Is the employer 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. Orientation Period Yes No
13. Waiting period before employees become insured (may not exceed 90 days):
    The 1st or 15th of the month following the waiting period of:
    0 days 30 days 60 days exactly 90 days for:
    Present Employees_______________ New Employees_______________ Rehired Employees_______________
14. Period for Annual Employee Open Enrollment.
15. What percentage of the total premium will the employer pay?
16. Deposit: $_______________ Premium Paid: Monthly Automatic checking withdrawal
    Premium will be due as of the effective date. The premium for the first month of coverage must be attached.
17. Affiliates, subsidiaries or branches (Must be included for purpose of participation)

Legal Name & Location	Number of full-time employees at this location	Number of part-time employees at this location

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Section II: Specifications for coverage

New business - Please choose from the plan options below.
Retention business - If renewing into new medical benefits, please choose from the plan options below.
Please check box if only selecting new dental benefits.

All AmeriHealth New Jersey Small Group plans are offered with a calendar year or plan year benefit period. When selecting an AmeriHealth New Jersey Small Group plan, place a check mark next to your plan of choice to indicate the benefit period option of calendar year or plan year.

To view the Summary of Benefits and Coverage (SBC) for your plans, visit amerihealthexpress.com or call 1-888-YOUR-AH (1-888-968-7241) (TTY:711) to request a paper copy.

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

Bronze Portfolio

Calendar Year	Plan Year	
		Select EPO HSA AmeriHealth Hospital Advantage $50/$75
		Select EPO HSA AmeriHealth Advantage $25/$50
		Select EPO HSA AmeriHealth Advantage RP with NY $25/$50
		Select EPO HSA Local Value 50%/50%
		Select EPO HSA Regional Preferred with NY 50%/50%
		Select EPO Local Value $50/$75
		Select EPO Regional Preferred with NY $50/$75
		EPO National Access with NY $50/$75

Silver Portfolio

Calendar Year	Plan Year	
		Select EPO HSA AmeriHealth Hospital Advantage $50/$75
		Select EPO AmeriHealth Advantage $30/$60
		Select EPO AmeriHealth Advantage RP with NY $30/$60
		Select EPO HSA Local Value 0%/0%
		Select EPO HSA Regional Preferred with NY 0%/0%
		HMO Local Value $50/$75
		HMO Regional Preferred $50/$75
		EPO HSA Local Value 0%/30%
		EPO HSA Regional Preferred with NY 0%/30%
		EPO HSA Local Value 0%/10%
		EPO HSA Regional Preferred with NY 0%/10%
		EPO HSA Local Value 20%/20%
		EPO HSA Regional Preferred with NY 20%/20%
		Select EPO Local Value $50/$75
		Select EPO Regional Preferred with NY $50/$75
		EPO HSA National Access with NY 0%/0%

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Gold Portfolio		
Calendar Year	**Plan Year**	
		Select EPO AmeriHealth Advantage $20/$40
		Select EPO AmeriHealth Advantage RP with NY $20/$40
		Select EPO AmeriHealth Hospital Advantage $30/$50
		Select EPO HSA Local Value 0%/0%
		Select EPO HSA Regional Preferred with NY 0%/0%
		Select EPO Local Value $30/$60
		Select EPO Regional Preferred with NY $30/$60
		EPO HSA Regional Preferred with NY 0%/20%
		EPO HSA Local Value 0%/0%
		EPO HSA Regional Preferred with NY 0%/0%
		EPO Local Value $35/$65
		EPO Regional Preferred with NY $35/$65
		EPO National Access with NY $35/$65
		EPO HSA National Access with NY 10%/10%
		HMO Regional Preferred $35/$75

Platinum Portfolio		
Calendar Year	**Plan Year**	
		EPO Regional Preferred with NY $10/$30
		EPO National Access with NY $10/$30

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AmeriHealth New Jersey SEH Ancillary Plans		
Adult Vision Options – Choose one: Calendar Year Plan Year		
Insured	Voluntary	
		Adult Vision Care 100/150
		Adult Vision Care 130/180
		Adult Vision Care 150/200
Pediatric Dental Options – Required		
Insured	Voluntary	
	N/A	SEH Pediatric Dental
		SEH Pediatric Dental with Adult Preventive
	N/A	SEH Family Dental
	N/A	SEH Family Plus Dental

The Patient Protection and Affordable Care Act (PPACA) allows for plans outside of the Small Business Health Options Program (SHOP) to issue coverage without pediatric dental benefits as long as the applicant provides reasonable assurance that an exchange-certified Stand-Alone Dental Plan (SADP) covering the pediatric dental benefits has been purchased elsewhere. To help you meet this requirement, AmeriHealth New Jersey is offering pediatric dental coverage through our SEH Pediatric Dental, SEH Pediatric Dental with Adult Preventive, and SEH Family Dental plans.

Attest to having pediatric dental coverage elsewhere

If you did not select one of the stand-alone pediatric dental plans listed above, we require one of the following options as proof of coverage in order to receive reasonable assurance from you.

Option 1 – Please provide supporting documentation such as:

- Copy of dental policy document, which includes specific reference to coverage of pediatric dental benefit; OR
- Welcome letter from dental carrier, which includes specific reference to coverage of pediatric dental benefit; OR
- Current invoice from dental carrier, which includes specific reference to coverage of pediatric dental benefit;

For new and retention business, please submit supporting documentation to your marketing representative.

Option 2 – Please provide the contact information of your pediatric dental carrier for proof of coverage by completing the section below.

Dental Carrier Name	Dental Product Name
Effective date for current Pediatric Dental coverage	Group Dental Policy Number

Section III: All questions must be answered

1. Is there any Group Health Plan
   - now in force and to be continued? Yes No
   - currently being applied for? Yes No

   If "Yes" identify the name of the Group Health Plan, give a description of the plan(s) and 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, give reason ________________________________
   e. Plan being replaced________________________________

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
   If yes, please provide the following information for each current/former employee or dependent on health continuations.

Name of Employess/Dependent	Date of Birth	Type of Continuation State/ Federal/Extended Benefits	Reason for Termination Disability/Other	Continuation Dates

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If additional space is needed, 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
   Additional space to explain if Items 1, 2 or 3 were answered "Yes". Refer to the question number, and give details including names, where appropriate.
   ____
   ____

6. Does the employer participate in an arrangement with a Professional Employer Organization (PEO)? 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 (Refer to the definition on the New Jersey Employer Certification). 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.

It is understood that I am responsible to provide AmeriHealth HMO, Inc. and AmeriHealth Insurance Company of New Jersey with timely and accurate information regarding the date of hire for new employees and that the requested effective date of coverage will properly apply any orientation period and waiting period requirements applicable to my plan. It is further understood that any retroactive termination requests must be limited to those for which no premium or contribution has been paid for the termination period by the employee or dependent whose coverage is to be retroactively terminated.

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 statements and answers given in this application (i.e. crossed out, whited-out, erased, information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.

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