



Small Group Member Coverage Application

Please Mail To:
 AmeriHealth New Jersey
 259 Prospect Plains Road,
 Building M, Cranbury, NJ 08512

AmeriHealth New Jersey	Group Information – to be completed by Employer:		
	Group Name:	Group Number:	Class Code:

A. Type of Activity – To be completed by Applicant. Refer to instructions before completing this form. Print clearly.

Activity – Check all that apply	Date of Event	Date of Hire/Reason for Change
Add <input type="checkbox"/> Enrollment of a new Subscriber <input type="checkbox"/> Add Spouse <input type="checkbox"/> Add Civil Union Partner <input type="checkbox"/> Add Domestic Partner <input type="checkbox"/> Add Dependent Child <input type="checkbox"/> Add Over-Age Child as a Dependent Under 31 <i>(and complete Coverage Continuation section)</i>		
Remove <input type="checkbox"/> Employee Withdrawal/Termination <input type="checkbox"/> Remove Subscriber <input type="checkbox"/> Remove Spouse <input type="checkbox"/> Remove Civil Union Partner <input type="checkbox"/> Remove Domestic Partner <input type="checkbox"/> Remove Dependent Child <input type="checkbox"/> Remove Over-Age Child as a Dependent Under 31		
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	For Employee	Length of Continuation (in months): 18 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	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	Length of Continuation (in months): 18 36	Date of Loss of Coverage:	Qualifying Event #: **	Date of Qualifying Event:	
	Dependent Under 31	Billing: Group Home (what address?) Section B OR Section F				

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: _____		

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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:		Zip+4:
	Ob/Gyn Loc #:	NPI or PCP ID #:	Current Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Address:		Zip+4:
	Dentist Loc #:	NPI or PCP ID #:	Current Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No
Address:		Zip+4:	
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: _____	
C. Plan Option – to be completed by the Employee		Medical Plan Name: _____	
D. Other Individuals Covered – <i>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.</i>			
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"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Other	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Other	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> 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)
<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
SSN	SSN	SSN	SSN
Eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No Covered under Medicare Parts A or B? <input type="checkbox"/> Yes <input type="checkbox"/> No Covered under any health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No Covered under Medicare Parts A or B? <input type="checkbox"/> Yes <input type="checkbox"/> No Covered under any health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No Covered under Medicare Parts A or B? <input type="checkbox"/> Yes <input type="checkbox"/> No Covered under any health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No Covered under Medicare Parts A or B? <input type="checkbox"/> Yes <input type="checkbox"/> No Covered under any health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Care Provider NPI or PCP ID #	Primary Care Provider NPI or PCP ID #	Primary Care Provider NPI or PCP ID #	Primary Care Provider NPI or PCP ID #
Address	Address	Address	Address
Zip+4	Zip+4	Zip+4	Zip+4
Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Ob/Gyn Office NPI or PCP ID #	Ob/Gyn Office NPI or PCP ID #	Ob/Gyn Office NPI or PCP ID #	Ob/Gyn Office NPI or PCP ID #
Address	Address	Address	Address
Zip+4	Zip+4	Zip+4	Zip+4
Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Dentist Office NPI or PCP ID #	Dentist Office NPI or PCP ID #	Dentist Office NPI or PCP ID #	Dentist Office NPI or PCP ID #
Address	Address	Address	Address
Zip+4	Zip+4	Zip+4	Zip+4
Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
If last name is different from Applicant, please explain	If last name is different from Applicant, please explain	If last name is different from Applicant, please explain	If last name is different from Applicant, please explain
Home address same as Applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If NO, complete Section E</i>	Home address same as Applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If NO, complete Section E</i>	Home address same as Applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If NO, complete Section E</i>	Home address same as Applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If NO, complete Section E</i>

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

Street/Apt		b. Please explain why the address is different	
Street/Apt			
City	State	Zip Code	

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): _____	Name(s): _____
Street/Apt: _____	Street/Apt: _____
Street/Apt: _____	Street/Apt: _____
City, State, Zip Code: _____	City, State, Zip Code: _____
Reason: _____	Reason: _____

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: _____
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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: _____
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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: _____
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Representative's Title: _____	
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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.
- 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.
- 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 by contacting the provider directly. 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.

Qualifying 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 understand that my enrollment and the enrollment of my listed dependents in AmeriHealth New Jersey's individual plan are subject to acceptance by AmeriHealth New Jersey.
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 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.