Fixed Funding Employee Enrollment Application

Please contact:
Fixed.funding@amerihealth.com

Please type or print all data clearly. If any data is missing or illegible, we must delay your enrollment until we receive a complete application.

Effective Date of Action:

1. Subscriber Information – Please complete this entire section, whether you are a new applicant or are making a change to an existing contract.

Social Security number		Last Name		First Name		Middle Initial		Gender	
Street Address		Apt or Suite		City		State		Zip Code	

Marital Status	Are you actively at work? Yes No	Date of Hire	Hours worked per week	Date of Birth
Single Married Domestic Partnership - Same Sex Domestic Partnership - Opposite Sex Divorced Separated Widowed	If no, please explain.			
		Title	Telephone Number including Area Code	
			Home	
		Email	Work	
			Cell	

2A. Dental		2B. Vision		2C. Medical Plan
Value 4 F-3W F-3WO	Other	Vision Care $100/$150 Vision Care $130/$180 Vision Care $150/$200	Other	

3. Dependent Information – Please provide all information for each person to be covered. Please attach additional sheets if required.

Spouse/ Domestic Partner Last Name	First Name	M.I.	Gender	Date of Birth	Social Security Number
Will other health insurance be in effect? If Yes, see Section 4. Yes No					
Child Last Name	First Name	M.I.	Gender	Date of Birth	Social Security Number
Will other health insurance be in effect? If Yes, see Section 4. Yes No					
Child Last Name	First Name	M.I.	Gender	Date of Birth	Social Security Number
Will other health insurance be in effect? If Yes, see Section 4. Yes No					
Child Last Name	First Name	M.I.	Gender	Date of Birth	Social Security Number
Will other health insurance be in effect? If Yes, see Section 4. Yes No					

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3. Dependent Information – Please provide all information for each person to be covered. Please attach additional sheets if required.

Child Last Name	First Name	M.I.	Gender	Date of Birth	Social Security Number
Will other health insurance be in effect? If Yes, see Section 4. Yes No					

4. Other Coverage Information

List health insurance information for you or any dependents with other coverage.	
Carrier Name	
Policy Holder	
Policy Number	Type of Benefits

Indicate whether any person to be covered is enrolled under Medicare Part A or B.		
Name	Medicare Number	
		Part A Part B
		Part A Part B
		Part A Part B

5. Medical History

Please answer the following questions for yourself and each person listed on the Enrollee and Dependent Information Section on page 1 of this form. Please answer completely and truthfully. Has anyone on this enrollment application form been diagnosed, consulted with, or been examined or treated by any health care professional during the last 5 years for any illness, injury, or health condition in any of the categories listed below? If yes, please check the box that most appropriately describes the problem and explain fully below. Please note that, if you fraudulently leave out or fraudulently misrepresent information, we may terminate or not renew your coverage, or we may change your monthly payment retroactive to the date your coverage became effective.
All statements contained in this entire form must be true and correct and no material information can be witheld or omitted.

Cancer/Tumor/Cyst

Brain Breast Esophagus Stomach Colon Leukemia Lymphoma Multiple Myeloma Kidney Liver Lung Melanoma
Pancreas Prostate Testicular Cervical Ovarian Uterine Throat Thyroid
Other N/A

Diagnosis Date (MM/DD/YYYY)	Cancer Stage (if known)	Treatment	Treatment Start Date (MM/DD/YYYY)	Treatment End Date (MM/DD/YYYY)	Remission	Remission Date (MM/DD/YYYY)
	1 2 3 4	Surgery Chemotherapy Radiation Other			YES NO	

Heart/Vascular

Aneurysm Blocked Arteries Heart Attack Heart Valve Disorder Congestive Heart Failure Cardiomypathy
Irregular or abnormal heart rhythm Stroke Vasculitis Bypass/Angioplasty/Stent Pacemaker or Cardiac Defribrilator
Other N/A

Blood/Clotting Disorder

Hemophilia Anemia Blood Clots
Other N/A

Reproductive/ Gynecological

Current Pregnancy Intending to Adopt Infertility
Other Gynecological conditions N/A

Due Date (pregnancy only) (MM/DD/YYYY)	Multiples (pregnancy only)	Complications (pregnancy only)	
		YES NO	

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5. Medical History	
Gastrointestinal/ Endocrine	Diabetes Crohn's/Ulcerative Colitis Autoimmune Hepatitis Acute Hepatitis B Chronic Hepatitis B Hepatitis C Cirrhosis Pancreatitis Growth Disorder Adrenal/Pituitary/Thyroid Gland disorder Other disorders of the gallbladder, stomach, pancreas, liver, colon N/A
Brain/Neurological	Amyotrophic lateral sclerosis Cerebral Palsy Neuropathy/Polyneuropathy Multiple Sclerosis Myasthenia Gravis Muscular Dystrophy Brain and/or Spinal Cord Disorder or Injury Paralysis/Quadriplegia/Paraplegia Other N/A
Immune/Dermatology	HIV or AIDS Immunodeficiency Disorder Connective Tissue Disorder Hereditary Angiodema Skin Disorder Other N/A
Urinary/Kidney	Kidney Disease/Disorder Kidney Failure Dialysis Dialysis possible within the next 18 months Bladder Disorder Prostate Disorder Other N/A
	Dialysis Start Date (if applicable)
Musculoskeletal	Rheumatoid or Psoriatic Arthritis Disorder of the Back/Neck/Spine Disorder of the Joints Chronic Pain Disorder Osteomyelitis Amputation Other N/A
Mental Health/ Substance Abuse	Alchohol and/or Drug Abuse Eating Disorder Anxiety/Depression Bipolar Disorder Schizophrenia Suicide Attempt Oppositional Defiant/Conduct Disorder Autism ABA Therapy Other N/A
Transplant	Organ or Bone Marrow/Stem Cell Transplant already performed Future Transplant Planned/Scheduled Transplant discussed/recommended/possible within the next 18 months Transplant complications Other N/A
	Date Performed/Scheduled (if applicable) (MM/DD/YYYY)
Birth/Inherited Conditions	Premature Birth Congenital Birth Defect Genetic/Metabolic Disorder Any Syndrome Other N/A
	Number of Gestational Weeks (premature only)
Eyes/Ears/Nose/Throat	Acoustic Neuroma Cataracts Cleft Lip/Palate Deviated Septum Glaucoma Retinopathy Chronic Ear Infections Chronic Sinusitis Other N/A

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5. Medical History

Medications	Current Medications:							
	Person 1 - # of Current Medications		Person 2 - # of Current Medications		Person 3 - # of Current Medications		Person 4 - # of Current Medications	
		None		None		None		None
	Medications taken within the past 12 Months:							
	Person 1 - # of Medications		Person 2 - # of Medications		Person 3 - # of Medications		Person 4 - # of Medications	
		None		None		None		None
Incapacitated	Disabled Handicapped Congenital Disorder Other N/A							
Other	Hospitalizations in the past 5 years Future surgeries or hospitalizations discussed/planned/recommended/scheduled or possible within the next 18 months Other conditions not addressed elsewhere in the application N/A							

6. Acknowledgement and Signature

Important Information About this Application

If you are applying for coverage that you are entitled to now or that you may become entitled to through your group health plan

When you sign below, you confirm that you understand that your coverage will start only after the Plan approves your application. If you leave out any information or if anything is unclear, we will contact you.

Your coverage will start after we receive all the necessary information. This coverage will be valid only if the statements that you make on this application are true and complete to the best of your knowledge.

You authorize the Plan and its agents to recover, collect, compromise, or sue in your name, or your enrolled dependent's name, for the amount of damages sustained. But the Plan is not required to do so.

Notice about fraudulent information

Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

If you decline coverage for yourself or your eligible dependents

When you sign below, you confirm that:

1. You understand that you are eligible for coverage under your employer's or organization's Plan.
2. You understand the coverage offered through the Plan.
3. You decline coverage for yourself or your eligible dependents.
4. You give up all claims to coverage under this Plan.
5. You understand that if you request coverage for yourself or your dependents in the future, you may not be offered coverage, except as allowed during a special enrollment period.

Special Enrollment Period

Other health coverage. If you do not enroll yourself or your dependents (including your spouse) now because you have other health coverage, you may be able to enroll yourself or your dependents in this Plan if your other coverage ends. You must ask to enroll within 30 days after your other coverage ends.

New dependent. If you have a new dependent due to marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, as long as you request enrollment within 30 days after the event.

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6. Acknowledgement and Signature

I have read and understand the "Important information about this application" section. I authorize any physician, hospital, pharmacy, employer, insurer, or other party to allow AmeriHealth New Jersey or their representatives, to view or receive copy or details of any medical data they have about me or my dependents, as needed to determine eligibility for benefits. I understand this information cannot be disclosed without my authorization. A copy of this authorization is as valid as the original. I hereby request the amount(s) of coverage for which I may become eligible. I authorize payroll deductions to pay my share of contributions, if any, when my coverage takes effect. I can revoke this authorization with written notice to my employer.

Employee Signature (REQUIRED)		Date	

Waiver (please complete if you are waiving medical coverage)

I waive medical coverage for:	Self (and dependents)	Please state reason for waiving coverage:			
Spouse	Dependent children	Qualifying coverage:		Other:	

If I have waived coverage for myself and/or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself and/or my dependents in the plan, provided that I request enrollment within 31 days after my other coverage ends because of involuntary loss of other coverage (divorce, death, legal separation, termination of employment, reduction in number of hours of employment). In addition, if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll my dependents, provided that I request enrollment within 31 days after the date of the event.

Applicant Signature X		**Date**	

7. Group and Employer Information – Your Group Administrator MUST complete this section. Your application CANNOT be processed unless this section is complete.

Account Name	Account Number	Subaccount Number (if applicable)	Payroll/Work Location

NEW	CHANGE		LIFE EVENT CHANGE	OTHER CHANGE	TERMINATE CONTRACT
New Hire Open Enrollment Waive Coverage	Address Name Rehire Life Event Benefit ID	Add a Dependent Delete a Dependent Return from Layoff Sub account Account	Marriage Newborn Loss of Health Coverage Divorce or Legal Separation Life Event Date:	COBRA Effective Date: Effective Date of Coverage	Terminated Employment Full Time to Part Time Deceased. Date Other. Please explain:

Employer or Group Administrator Signature (REQUIRED)	Date

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