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

AmeriHealth New Jersey Small Group Member Coverage Application

AmeriHealth New Jersey	Group Information – to be completed by Employer:		
AmeriHealth New Jersey	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	☐ Enrollment of a new Subscriber	/ /	Date: / / Reason:
	☐ Add Spouse	/ /	Date: / / Reason:
	☐ Add Civil Union Partner	/ /	Date: / / Reason:
	☐ Add Domestic Partner	/ /	Date: / / Reason:
	☐ Add Dependent Child	/ /	Date: / / Reason:
	☐ Add Over-Age Child as a Dependent Under 31 *(and complete Coverage Continuation section)*	/ /	Date: / / Reason:
REMOVE	☐ Employee Withdrawal/Termination	/ /	Date: / / Reason:
	☐ Remove Spouse	/ /	Date: / / Reason:
	☐ Civil Union Partner	/ /	Date: / / Reason:
	☐ Remove Domestic Partner	/ /	Date: / / Reason:
	☐ Remove Dependent Child	/ /	Date: / / Reason:
	☐ Remove Over-Age Child as a Dependent Under 31	/ /	Date: / / Reason:
OTHER CHANGES	☐ Name Change	/ /	
	☐ Change Plan	/ /	
	☐ Other	/ /	
	☐ Add/Change Office ID Numbers: Primary/OB/Gyn/Dentist **See list of Triggering Events in Instructions*	/ /	

COVERAGE CONTINUATION

☐ For Employee	☐ Total Disability* ☐ COBRA/NJSGC	Length of Continuation (in months): ☐ 18 ☐ 29	Date of Loss of Coverage: / /	Qualifying Event #: **	Date of Qualifying Event: / /
Billing: ☐ Group ☐ Home (Section B)				***Attach proof of disability**	
☐ For Spouse/Civil Union Partner*	Length of Continuation (in months): ☐ 18 ☐ 36	Date of Loss of Coverage: / /	Qualifying Event #: **	Date of Qualifying Event: / /	
Billing: ☐ Group ☐ Home (what address?) ☐ Section B OR ☐ Section E			***Civil union partners are eligible to make an election pursuant to NJSGC, if applicable.**		
☐ For Dependent/ Over-age Child	☐ COBRA/NJSGC	Length of Continuation (in months): ☐ 18 ☐ 36	Date of Loss of Coverage: / /	Qualifying Event #: **	Date of Qualifying Event: / /
☐ Dependent Under 31	Qualifying Event #: **	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: ☐ M ☐ 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:

50196

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ACTIVITY	☐ Add ☐ Remove ☐ Continuation ☐ Other Change – *If a name change, indicate prior name:*		
	Primary Loc #:	NPI or PCP ID #:	Current Patient: ☐ Yes ☐ No
	Address:		Zip+4:
	Ob/Gyn Loc #:	NPI or PCP ID #:	Current Patient: ☐ Yes ☐ No
	Address:		Zip+4:
	Dentist Loc #:	NPI or PCP ID #:	Current Patient: ☐ Yes ☐ No
	Address:		Zip+4:

Other Health Coverage? ☐ Yes ☐ No If yes: Payer Name: ______ Policy #: ______ Medicare ID#, if any: ______	Other Rx Coverage? ☐ Yes ☐ 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 – to be completed by the Employee *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 if necessary.*

1.Spouse/Domestic Partner/ Civil Union Partner	2. Child	3. Child	4. Child
☐ Add ☐ Remove ☐ Other ☐ Continue Spouse ☐ Continue CU Partner (NJSGC)	☐ Add ☐ Remove ☐ Other ☐ Continue	☐ Add ☐ Remove ☐ Other ☐ Continue	☐ Add ☐ Remove ☐ Other ☐ Continue
Name (last, first, MI) L:______ F:______ MI:	Name (last, first, MI) L:______ F:______ MI:	Name (last, first, MI) L:______ F:______ MI:	Name (last, first, MI) L:______ F:______ MI:
Birthdate (mm/dd/yyyy):___/___/___	Birthdate (mm/dd/yyyy):___/___/___	Birthdate (mm/dd/yyyy):___/___/___	Birthdate (mm/dd/yyyy):___/___/___
☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Social Security Number:	Social Security Number:	Social Security Number:	Social Security Number:
Other health coverage ☐ No ☐ Yes – If Yes: Payer Name: ______ Policy #: ______ Medicare ID #: ______	Other health coverage ☐ No ☐ Yes – If Yes: Payer Name: ______ Policy #: ______ Medicare ID #: ______	Other health coverage ☐ No ☐ Yes – If Yes: Payer Name: ______ Policy #: ______ Medicare ID #: ______	Other health coverage ☐ No ☐ Yes – If Yes: Payer Name: ______ Policy #: ______ Medicare ID #: ______
Other Rx Coverage: ☐ No ☐ Yes – If Yes: Payer Name: ______ Policy #: ______ Medicare ID #: ______	Other Rx Coverage: ☐ No ☐ Yes – If Yes: Payer Name: ______ Policy #: ______ Medicare ID #: ______	Other Rx Coverage: ☐ No ☐ Yes – If Yes: Payer Name: ______ Policy #: ______ Medicare ID #: ______	Other Rx Coverage: ☐ No ☐ Yes – If Yes: Payer Name: ______ Policy #: ______ Medicare ID #: ______
Primary Care Provider: NPI or PCP ID #: ______ Address: ______ Current Patient? ☐ Yes ☐ No	Primary Care Provider: NPI or PCP ID #: ______ Address: ______ Current Patient? ☐ Yes ☐ No	Primary Care Provider: NPI or PCP ID #: ______ Address: ______ Current Patient? ☐ Yes ☐ No	Primary Care Provider: NPI or PCP ID #: ______ Address: ______ Current Patient? ☐ Yes ☐ No
Ob/Gyn Office NPI or PCP ID #: ______ Address: ______ Current Patient? ☐ Yes ☐ No ☐ NA	Ob/Gyn Office NPI or PCP ID #: ______ Address: ______ Current Patient? ☐ Yes ☐ No ☐ NA	Ob/Gyn Office NPI or PCP ID #: ______ Address: ______ Current Patient? ☐ Yes ☐ No ☐ NA	Ob/Gyn Office NPI or PCP ID #: ______ Address: ______ Current Patient? ☐ Yes ☐ No ☐ NA
Dentist Office NPI or PCP ID #: ______ Address: ______ Current Patient? ☐ Yes ☐ No	Dentist Office NPI or PCP ID #: ______ Address: ______ Current Patient? ☐ Yes ☐ No	Dentist Office NPI or PCP ID #: ______ Address: ______ Current Patient? ☐ Yes ☐ No	Dentist Office NPI or PCP ID #: ______ Address: ______ Current Patient? ☐ Yes ☐ No

Employed? ☐ Yes ☐ No *If yes, complete Section E1*	If last name is different from Employee's, please explain: __________ __________	If last name is different from Employee's, please explain: __________ __________	If last name is different from Employee's, please explain: __________ __________
Home or billing address same as Employee? ☐ Yes ☐ No *If NO, complete Section E2*	Living with Employee? ☐ Yes ☐ No *If NO, complete Section F*	Living with Employee? ☐ Yes ☐ No *If NO, complete Section F*	Living with Employee? ☐ Yes ☐ No *If NO, complete Section F*

E. Additional Spouse/Civil Union Partner/Domestic Partner Information – to be completed by Employee. *If not applicable, please mark as "NA."*

1.	Employer Name:__________ Employer Address:__________ City, State, Zip Code:__________ Phone:__________
2.a	Street/Apt:__________ Street/Apt:__________ City, State, Zip Code:__________
2.b	Please explain why the address is different:__________ __________ __________

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

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:___/___/___

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:___/___/___
Representative's Title:	

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 from the provider directory on www.amerihealthnj.com or 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 group plan.
5. 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 group plan if premiums are not paid timely. I authorize my Employer to withhold payments from my wages as contribution to the premium, as appropriate.

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.

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