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New Jersey 2018 Employee Enrollment Application / Change Request

Instructions: You, the employee, must complete this application. You are solely responsible for its accuracy and completeness. To avoid the possibility of delay, answer all questions and be sure to sign and date your application. Please complete this form in blue or black ink and submit to your employer when complete.

Section A: Information provided by your employer (to be completed by the employer)

Employer name	Employer group ID (ex: BIZ12345678)	
Employee's work address		
City	State	ZIP code
Employment status (check all options that apply):	☐ Active ☐ Union ☐ Non-union ☐ Hourly ☐ Salary ☐ Other (please explain):	
Employee's class	Date of hire (mm/dd/yyyy)	Hours worked per week

Section B: Application type

Application type

☐ New application ☐ Change benefits plan ☐ Information update (name, address, etc.)
☐ Add/remove a dependent ☐ Termination

Application reason

☐ Open enrollment ☐ New hire ☐ Rehire
☐ COBRA ☐ New Jersey Small Group Continuation (NJSGC) ☐ Qualifying Life Event
☐ Other (please explain):

If you selected **COBRA** or **NJSGC** as the application reason above, please select one of the following qualifying life events:

- ☐ Left employment
- ☐ Reduction in hours
- ☐ Death
- ☐ Divorce or legal separation
- ☐ Loss of dependent child status
- ☐ Medicare entitlement

Continuation qualifying event date (mm/dd/yyyy):

If you selected **Qualifying Life Event** as the application reason above, please select one of the following applicable qualifying life events:

- ☐ Loss of coverage*
- ☐ Marriage
- ☐ Birth
- ☐ Adoption*
- ☐ Court-ordered dependent addition*
- ☐ Moved to service area*

Other qualifying event date (mm/dd/yyyy):

* Indicates that appropriate documentation must be submitted along with this form to be eligible for coverage.

Section C: Member information

Instructions: The below information must be completed for the subscriber and any additional family members to be covered. An eligible dependent may be your spouse, domestic partner, your children, your spouse's children or your domestic partner's children, at the option of your employer.

Coverage of a child dependent will continue to the end of the calendar month in which the child turns age 26 unless:

- He or she qualifies as a disabled person (if you have a disabled dependent, please call us at (855) 672-2784 to request a disabled dependent form).
- Your dependent qualifies for and enrolls in the Over-Age Child Dependent Under 31, which extends coverage for young adults through age 31.

	Employee	Spouse	Child	Child 2
Full name				
Social security number	☐ Not available	☐ Not available	☐ Not available	☐ Not available
Check all that apply:		☐ Domestic partner ☐ Employee of this business	☐ Disabled ☐ Dependent under 31 ☐ Employee of this business	☐ Disabled ☐ Dependent under 31 ☐ Employee of this business
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Date of birth (mm/dd/yyyy)				
For the section below, if all members share the same details - only fill out the first column. However, if there are differences or if a dependent is enrolling as a Young Adult, please fill out the other respective columns.				
Address line 1				
Address line 2 (optional)				
City				
State				
ZIP code				
County				
Phone (xxx) xxx - xxxx				
Email				
On the day your coverage begins, if you or any of your family members will be eligible or covered by Medicare or other coverage fill out the section below.				
Eligible for Medicare	☐ Yes ☐ No If yes, why? ☐ Age ☐ Disability ☐ ESRD Onset date:	☐ Yes ☐ No If yes, why? ☐ Age ☐ Disability ☐ ESRD Onset date:	☐ Yes ☐ No If yes, why? ☐ Age ☐ Disability ☐ ESRD Onset date:	☐ Yes ☐ No If yes, why? ☐ Age ☐ Disability ☐ ESRD Onset date:

Medicare coverage (check appropriate box and list effective date and Medicare ID number)	☐ Part A: ☐ Part B: ☐ Part C: ☐ Part D: ID number:	☐ Part A: ☐ Part B: ☐ Part C: ☐ Part D: ID number:	☐ Part A: ☐ Part B: ☐ Part C: ☐ Part D: ID number:	☐ Part A: ☐ Part B: ☐ Part C: ☐ Part D: ID number:
Other health coverage (check appropriate box and list coverage dates, carrier name and Policy number)	☐ Individual ☐ Group Start date: End date: Carrier name: Policy number:	☐ Individual ☐ Group Start date: End date: Carrier name: Policy number:	☐ Individual ☐ Group Start date: End date: Carrier name: Policy number:	☐ Individual ☐ Group Start date: End date: Carrier name: Policy number:

Section D: Choose your plan

Not all plans listed may be available - check with your employer for more details. All plans below include pediatric dental coverage.

- ☐ Classic Platinum EPO
- ☐ Classic Platinum 20% EPO
- ☐ Classic Gold $0 $4,500 EPO
- ☐ Classic Gold $0 $5,000 EPO
- ☐ Classic Gold $0 $7,000 EPO
- ☐ Classic Gold $1,000 $7,000 EPO
- ☐ Classic Gold $1,500 EPO
- ☐ Classic Gold $1,000 $5,500 EPO
- ☐ Classic Silver $2,000 30% EPO
- ☐ Classic Silver $2,000 50% EPO
- ☐ Classic Silver $2,500 30% EPO
- ☐ Classic Silver $2,500 50% EPO
- ☐ Classic Silver $1,500 EPO
- ☐ Classic Bronze $2,500 EPO
- ☐ Classic Bronze $3,000 EPO
- ☐ Backup Silver $2,500 $6,000 $7,000 $18,000 PPO
- ☐ Backup Silver $2,500 EPO
- ☐ Backup Silver $2,000 EPO

Section E: Terms, conditions, and authorizations

Please read this section carefully before signing the application:

W-9 Certification:
As part of the W-9 Certification required by the Internal Revenue Service (IRS), I certify that the Social Security number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me) and I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding and I am a U.S. citizen or other U.S. person.

In signing this, I represent that:
I am an Eligible Employee (as defined by New Jersey state and federal law), and I am requesting coverage for myself and all Eligible Dependents (as defined by New Jersey state and federal law) listed and authorize my Employer to deduct any required contributions for this insurance from my earnings. I understand all benefits are subject to conditions stated in the Group Contract and coverage documents.

I have read or have had read to me the completed application, and I realize any false statement or misrepresentation in the application may result in loss of coverage.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicant signature	Date (mm/dd/yyyy)
Sign here **X**	