


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

Small Group Member Coverage Application

		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. <i>Refer to instructions before completing this form. Print clearly.</i>						
	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	<input type="checkbox"/> For Employee	<input type="checkbox"/> Total Disability* <input type="checkbox"/> COBRA/NJSGC	Length of Continuation (in months): <input type="checkbox"/> 18 <input type="checkbox"/> 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*	Length of Continuation (in months): <input type="checkbox"/> 18 <input type="checkbox"/> 36	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	<input type="checkbox"/> COBRA/NJSGC	Length of Continuation (in months): <input type="checkbox"/> 18 <input type="checkbox"/> 36	Date of Loss of Coverage:	Qualifying Event #: **	Date of Qualifying Event:
	<input type="checkbox"/> Dependent Under 31	Qualifying Event #: **	Billing: <input type="checkbox"/> Group <input type="checkbox"/> Home (what address?) <input type="checkbox"/> Section B OR <input type="checkbox"/> 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.

Language Taglines and Nondiscrimination Notice

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意: 如果您讲中文, 您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કોલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic: ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzsch, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考: 母国語が日本語の方は、言語アシスタンスサービス(無料)をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):

توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh. Hódííłnih kojí' 1-800-275-2583.

Urdu:

توجہ درکار ہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍: ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះ ជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

Language Taglines and Nondiscrimination Notice

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.