AmeriHealth

ENROLLMENT/CHANGE FORM

For all plans, including New Jersey Small Group Employer Benefits Program

Send to:
AmeriHealth Enrollment
P.O. Box 42555
Philadelphia, PA 19101-2555

1 Plan (please specify Fast Track or Standard)

1A Standard Plans (Indicate co-pay amount and deductible)

HMO	POS	PPO	CMM	Rx	Vision	Dental

1B Fast Track (Circle co-pay)

HMO		POS		PPO	
$10	$20	$10	$20	$10	$20

2 Subscriber/Member Enrollment or Change - Employee Must Complete in Full

❑ **New Application**
- ❑ New Hire
- ❑ Open Enrollment
- ❑ Life Event Change

Complete all information and sign form.

❑ **Information Change**
Provide your Identification Number below and indicate the change(s) you are making. Complete appropriate section(s) and sign at bottom of form.
I.D. # _____

❑ **Change**
- ❑ Address
- ❑ Last Name
- ❑ Primary Care Office
- ❑ Rehire
- ❑ DentalOffice

❑ **Dependent Membership Change**
- ❑ Add Dependent
  If adding spouse, indicate marriage date ___/___/___
- ❑ Delete Dependent

❑ **Other Change**
- ❑ COBRA ❑ Conversion
- ❑ 18 mos. eff. date: ___/___/___
- ❑ 29 mos. eff. date: ___/___/___
- ❑ 36 mos. eff. date: ___/___/___

❑ **Terminate Contract**
- ❑ Terminated Employment
- ❑ Full-time to Part-time
- ❑ Deceased, date: ___/___/___
- ❑ Open Enrollment
- ❑ Other:_____

3 Subscriber Information

NOTE: Please complete this section in its entirety, whether you are a new applicant or are making a change to an existing contract.

Social Security Number	Last Name	First Name	Middle Initial	Sex	Date of Birth month/day/year
				❑ M ❑ F	

Street Address | City | State | Zip Code

Telephone Number (include area code) Home: ___ Work: ___

Employment Status: ❑ Active ❑ COBRA ❑ Retiree

Marital Status: ❑ Single ❑ Divorced ❑ Married ❑ Separated ❑ Widowed

Previous Health Insurance

3A Group/Employer Information

Your **Group Administrator** must complete this section. This form **cannot be processed** without this information.
❑ **Check if National Account**

Group Number	Group Name (Full Legal Name of Company)
Account Number	Group Address

Employer Signature and Date
08/80/8888

Date of Hire	Date Coverage/Change is Effective
	___/___/___
Payroll/Work Location	Location Name/Phone #

3B Complete this section for HMO or POS Only

Primary Care Office Name — If Current Physician Check This Box ❑
Primary Care Office Code Number

Primary Dental Office Name — If Current Dentist Check This Box ❑
Primary Dental Office Code Number

4 Dependent Information - Please provide all information for each person to be covered.

Full Name Last Name	First Name	Middle Initial	Sex	Date of Birth Month/day/year	Social Security Number	4A Primary Care Office Name (If current physician, check box at right.)	4A Primary Care Office Number	4B Overage Student? Please attach verification.	4B Disabled? Please attach verification.
Spouse			❑ M ❑ F						
Child			❑ M ❑ F					❑ Yes ❑ No	❑ Yes ❑ No
Child			❑ M ❑ F					❑ Yes ❑ No	❑ Yes ❑ No
Child			❑ M ❑ F					❑ Yes ❑ No	❑ Yes ❑ No

4C
If you have listed any dependents in the Dependent Information Section, **you must answer the questions below.**
Do any of the dependents listed in this section live at another address?
❑ Yes ❑ No
If yes, who and at what address? Explain the circumstances:

If any dependent's last name is different from yours, explain the circumstances:

5 Other Insurance Information

To be sure that you receive all the benefits to which you are entitled, you must complete the following:

5A Is your spouse employed? ❑ Yes ❑ No
If yes, please give name, address, and phone number of spouse's employer _____

5B Are you or any of your dependents currently receiving Medicare benefits
❑ Yes ❑ No If yes, please give name of recipient.

	PART A	EFFECTIVE DATE	PART B	EFFECTIVE DATE	MEDICARE CLAIM NUMBER
SELF					
SPOUSE					
CHILD					

If Medicare Information Has Been Entered It Will Appear on the Following Page(s)

5C When you become effective with our policy, will any persons listed on this enrollment form be covered by any other health insurance policy?
❑ Yes ❑ No
If yes, please give name and policy no. of insurance carrier and type of benefits.

Who is covered by this policy? List names of those covered.
(1) _____
(2)

If Other Medical Coverage Has Been Entered It Will Appear on the Following Page(s)

Important: Please read the back of this form, then sign below.

_____ **Signature of Employee**

_____ **Date Signed**

Copy 1: AmeriHealth

Employee Name: ____ SSN: _______________________________

Last Name	First Name	M.I.	Sex	Date of Birth	Social Security Number	Primary Care Office Name	Primary Care Office Number	Current Patient	Overage Student?	Disabled?
			☐ M ☐ F					☐	☐ Yes ☐ No	☐ Yes ☐ No
			☐ M ☐ F					☐	☐ Yes ☐ No	☐ Yes ☐ No
			☐ M ☐ F					☐	☐ Yes ☐ No	☐ Yes ☐ No
			☐ M ☐ F					☐	☐ Yes ☐ No	☐ Yes ☐ No
			☐ M ☐ F					☐	☐ Yes ☐ No	☐ Yes ☐ No
			☐ M ☐ F					☐	☐ Yes ☐ No	☐ Yes ☐ No
			☐ M ☐ F					☐	☐ Yes ☐ No	☐ Yes ☐ No
			☐ M ☐ F					☐	☐ Yes ☐ No	☐ Yes ☐ No
			☐ M ☐ F					☐	☐ Yes ☐ No	☐ Yes ☐ No
			☐ M ☐ F					☐	☐ Yes ☐ No	☐ Yes ☐ No
			☐ M ☐ F					☐	☐ Yes ☐ No	☐ Yes ☐ No
			☐ M ☐ F					☐	☐ Yes ☐ No	☐ Yes ☐ No
			☐ M ☐ F					☐	☐ Yes ☐ No	☐ Yes ☐ No
			☐ M ☐ F					☐	☐ Yes ☐ No	☐ Yes ☐ No
			☐ M ☐ F					☐	☐ Yes ☐ No	☐ Yes ☐ No
			☐ M ☐ F					☐	☐ Yes ☐ No	☐ Yes ☐ No

COMPLETE THIS SECTION IF APPLYING FOR COVERAGE UNDER THE NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM ONLY.

Occupation: _____ Title: _____ Date of Employment: _____ Hours Worked Per Week: _____ Are you actively at work? ____ Yes ____ No
If "No", explain: _____

If you are declining enrollment for yourself or your dependents (including your spouse) because of other Group Health Plan coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Persons to be covered: ❑ Employee Only ❑ Employee & Child(ren) ❑ Employee & Spouse ❑ Employee, Spouse & Child(ren)

Which coverage have you selected to be primary in the event expenses are incurred as a result of an automobile related injury? ____ Auto ____ Medical

Are you replacing existing coverage? ____ Yes ____ No If "Yes", give the name and policy number of the replaced carrier, the effective and termination dates, and the name(s) of the persons covered by the policy_____
_____

Were you, or any dependent(s) to be covered, covered under a prior Group Health Plan? ____ Yes ____ No If "Yes", attach the Certificate of Group Health Plan Coverage. Please note that if you do not provide the Certificate of Group Health Plan Coverage, you and any dependents to be covered, may be required to satisfy the preexisting conditions limitation, if applicable.

DECLARATION AUTHORIZATION AND CONDITIONS OF ACCEPTANCE FOR THE NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM

I hereby enroll for the group coverage to which I am or may be entitled. I authorize deductions from my pay for my share of the cost, if any.

I represent that to the best of my knowledge and belief, the statements and answers given above are true and complete. I understand that the information shall form the basis upon which I may be included for coverage under the group plan.

I understand that:

a) the coverage applied for will not take effect unless:
   - after review of this Enrollment Form, AmeriHealth accepts it;
   - the first premium has been paid to AmeriHealth; and
   - I am either actively at work for full pay on a full-time basis on the date coverage is to take effect, or subject to applicable regulations, I qualify under a waiver of the active work requirement

b) no person, except an officer of AmeriHealth has authority to: determine whether certificate/evidence of coverage shall be issued based on this Enrollment Form, waive or modify any of the provisions of the Enrollment Form, or any of the AmeriHealth Requirements; to bind AmeriHealth by any statement or promise pertaining to any certificate/evidence of coverage to be issued on the basis of this Enrollment Form; or accept any information or representation not contained in the written Enrollment Form.

c) the Employer is hereby designated my representative for the purpose of receiving contributions and remitting them to AmeriHealth.
   - AmeriHealth does not pay benefits for charges, or provide services or supplies related to a preexisting condition for 180 days, measured from the enrollment date. I understand that a Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a person's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date. I also understand that New Jersey Law only permits the application of the preexisting conditions limitation under certain circumstances and that I or my dependents will only be subject to this limitation to the extent permitted by New Jersey Law.

I understand that by signing below when I file a claim, AmeriHealth may pay the health care benefits directly to the provider instead of to me.

I state that I am a resident of New Jersey and I live, reside or work within AmeriHealth's service area. I understand that if I omit or falsify any statement on this enrollment form, AmeriHealth can cancel my coverage as of the original effective date.

Any person who includes any false or misleading information on an application or enrollment form and change form for a health benefits plan is subject to criminal and civil penalties.

Note: A person who was covered under Creditable Coverage has a right to request a certificate from the prior plan or issuer to demonstrate that he or she was covered under Creditable Coverage. If necessary, AmeriHealth will assist the person in obtaining a certificate from the prior plan or issuer.

Conditions of Acceptance

On behalf of myself and the dependents listed on this Enrollment Form, I agree to or with the following:

1. Employee is applying for coverage for the employee, employee's spouse and any eligible unmarried children under nineteen (19) years of age, unmarried children who are mentally or physically incapacitated and who are chiefly dependent upon the employee or the employee's spouse for support and maintenance or are unmarried children between the ages of nineteen (19) and twenty-three (23) who are enrolled as full-time students at an accredited school.
2. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the Contract.
3. The Contract will determine the rights and responsibilities of members and will govern in the event it conflicts with any benefits comparison, summary or other description of the health benefits plan.
4. As a condition to receiving in-network benefits, employee understands and agrees that with the exception of emergency procedures as defined in the Contract all in-network services, in order to be covered by AmeriHealth, must be performed either by a participating primary care physician or by the participating specialist, hospital or other provider as authorized by prior written referral from the participating primary care physician. Out-of-network benefits are covered, as stated in the contract.
5. Employee agrees to make payment directly to health care providers such copayments as are provided in the employer's health benefits plan.
6. Employer understands that this coverage will remain in effect regardless of the continued availability of a particular primary care physician.
7. Employee acknowledges that AmeriHealth's participating providers, including all participating primary care physicians, are independent contractors and are not agents or employees of AmeriHealth.

Authorization

1. I authorize the sources stated below to give to AmeriHealth, or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, advice, treatment or supplies for any physical or mental condition. Authorized sources are: any physician or medical professional; any hospital, clinic or other medical care institution; any carrier; any consumer reporting agency; any employer.
2. I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which AmeriHealth has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
3. I know that I have a right to receive a copy of this authorization if I request one.
4. I agree that a photocopy of this authorization is as valid as the original.

I understand that if I choose an HMO Product the provision of services to me and my dependents as Members of AmeriHealth is governed by the applicable Group Master Contract, which provides that: 1) except for emergencies, all medical or dental care must be initialed at the primary care office or primary dental office (as appropriate) we have selected; and 2) and my dependents authorize any person or organization providing services to furnish AmeriHealth with medical or dental records or other information concerning such services for purposes of AmeriHealth quality and utilization review. I understand that if I choose a Point of Service Product, I will be subject to applicable deductible, coinsurance and other copayments for all non-referred services, as specified in the contract. I further understand that I can change health plan coverage only at the time my employer and AmeriHealth specify.

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 material 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 subjects such person to criminal and civil penalties.