AmeriHealth NEW JERSEY

Please mail to:
AmeriHealth Insurance Company of New Jersey
AmeriHealth HMO, Inc.
259 Prospect Plains Road, Building M, Cranbury, NJ 08512
Tel 215-640-7573 | Fax 215-238-7940 | www.amerihealthnj.com

Individual Coverage Application

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	Reason
Add	☐ Enrollment of a new Subscriber ☐ Add Spouse ☐ Add Civil Union Partner ☐ Add Domestic Partner ☐ Add Dependent Child		
Remove	☐ Remove Subsriber ☐ Remove Spouse ☐ Remove Civil Union Partner ☐ Remove Domestic Partner ☐ Remove Dependent Child		
Other Changes	☐ Name Change ☐ Change Plan ☐ Special Enrollment Period (due to a Triggering Event*) ☐ Other ☐ Add/Change Office ID Numbers: Primary/OB/Gyn/Dentist		
	*See list of Triggering Events in instructions. Provide evidence of triggering event with the enrollment form		

B. Applicant Information

Name (Last, First, MI)		SSN	Birthdate (mm/dd/yyyy)
Email			
By providing an email address you consent to receive information, including the policy, by electronic means.			
☐ Male ☐ Female	Are you a resident of New Jersey? ☐ Yes ☐ No	Do you maintain a home in any other state or country? ☐ Yes ☐ No ***If yes to the above***, name of state/country Number of months you live there each year	

Address Information	**Primary Residence**		
	Street/Apt		
	Street/Apt	City	
	State	Zip Code	Phone
	Other Residence		
	Street/Apt		
	Street/Apt	City	
	State	Zip Code	Phone
	Your billing address: ☐ Primary residence ☐ Other residence ☐ P.O. Box or Other *(specify)* Mailing address (for communications other than bills: ☐ Primary residence ☐ Other residence ☐ P.O. Box or Other (specify)		
Activity	☐ Add ☐ Remove ☐ Other Change ☐ Continue *If a name change, indicate prior name:*		
	Primary Loc #	NPI or PCP ID #	
	Address	Zip +4	Current Patient? ☐ Yes ☐ No
	Ob/Gyn Loc #	NPI or PCP ID #	
	Address	Zip +4	Current Patient? ☐ Yes ☐ No
	Dentist Loc #	NPI or PCP ID #	
	Address	Zip +4	Current Patient? ☐ Yes ☐ No

Are you eligible for Medicare? ☐ Yes ☐ No Are you covered under Medicare Parts A or B? ☐ Yes ☐ No Please note: If you are eligible for Medicare, the individual policy will coordinate as secondary payor to what Medicare paid or would have paid. Individual policies do not operate as Medicare supplement policies.	Are you covered under any health coverage? ☐ Yes ☐ No If yes, why are you applying for individual coverage?

Individual Coverage Application

C. Insert Plan Options:

☐ Medical Plan Name:

AmeriHealth New Jersey Ancillary Plans

Pediatric Dental Options

Required: ☐ IHC Pediatric Dental ☐ IHC Pediatric Dental with Adult Preventative ☐ Attest to having pediatric dental coverage elsewhere

IMPORTANT: The Patient Protection and Affordable Care Act (PPACA) requires that you have pediatric dental coverage. To help you meet that requirement, AmeriHealth New Jersey has pre-selected our two Pediatric Dental plan options which provide coverage for you and any eligible family members including pediatric dental coverage as required by PPACA. If you do not select either the IHC Pediatric Dental, or IHC Pediatric Dental with Adult Preventative dental plans, you must attest to having pediatric dental coverage elsewhere.

Adult Vision Options

☐ Adult Vision 100 ☐ Adult Vision 150 ☐ Adult Vision 180

D. Other Individuals Covered – *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.*

1.Spouse/Domestic Partner/ Civil Union Partner	2. Child	3. Child	4. Child
☐ Add ☐ Remove ☐ Other	☐ Add ☐ Remove ☐ Other	☐ Add ☐ Remove ☐ Other	☐ Add ☐ Remove ☐ 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)
☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
SSN	SSN	SSN	SSN
Eligible for Medicare? ☐ Yes ☐ No Covered under Medicare Parts A or B? ☐ Yes ☐ No Covered under any health coverage? ☐ Yes ☐ No	Eligible for Medicare? ☐ Yes ☐ No Covered under Medicare Parts A or B? ☐ Yes ☐ No Covered under any health coverage? ☐ Yes ☐ No	Eligible for Medicare? ☐ Yes ☐ No Covered under Medicare Parts A or B? ☐ Yes ☐ No Covered under any health coverage? ☐ Yes ☐ No	Eligible for Medicare? ☐ Yes ☐ No Covered under Medicare Parts A or B? ☐ Yes ☐ No Covered under any health coverage? ☐ Yes ☐ 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 _____ _____ Zip+4 _____	Address _____ _____ Zip+4 _____	Address _____ _____ Zip+4 _____	Address _____ _____ Zip+4 _____
Current Patient? ☐ Yes ☐ No	Current Patient? ☐ Yes ☐ No	Current Patient? ☐ Yes ☐ No	Current Patient? ☐ Yes ☐ 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 _____ _____ Zip+4 _____	Address _____ _____ Zip+4 _____	Address _____ _____ Zip+4 _____	Address _____ _____ Zip+4 _____
Current Patient? ☐ Yes ☐ No	Current Patient? ☐ Yes ☐ No	Current Patient? ☐ Yes ☐ No	Current Patient? ☐ Yes ☐ 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 _____ _____ Zip+4 _____	Address _____ _____ Zip+4 _____	Address _____ _____ Zip+4 _____	Address _____ _____ Zip+4 _____
Current Patient? ☐ Yes ☐ No	Current Patient? ☐ Yes ☐ No	Current Patient? ☐ Yes ☐ No	Current Patient? ☐ Yes ☐ 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? ☐ Yes ☐ No *If NO, complete Section E*	Home address same as Applicant? ☐ Yes ☐ No *If NO, complete Section E*	Home address same as Applicant? ☐ Yes ☐ No *If NO, complete Section E*	Home address same as Applicant? ☐ Yes ☐ No *If NO, complete Section E*

Individual Coverage Application

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 – *Provide information below about children listed in Section D, if they have a different address. 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	Phone
Reason		
Name(s)		
Street/Apt		
Street/Apt	City	
State	Zip Code	Phone
Reason		

G. Race / Ethnicity – *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. Payment Information – *Indicate how you would like to be billed and make payment.*

☐ Monthly ☐ Check ☐ Money Order

I. Applicant's 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.

Signature	Date

J. Broker/General Agent Signature

Signature of Preparer	Date	☐ NJ Producer License # ☐ NPN
General Agent		Agent ID #

AmeriHealth NEW JERSEY

Individual Coverage Application

Instructions and Eligibility Requirements

Instructions

- Except for section G, you must complete sections A through I, and sign and date this form, as well as any additional pages you may need to submit with it to provide further requested information.
- Please PRINT except when a signature is requested.
- If a dependent child is disabled and you want to continue his or her coverage beyond age 26, describe this in "Other Change" in Section A, and attach proof of disability.
- If you are applying to add a spouse, civil union partner, domestic partner, or child please check the applicable box in the "Add" section in A **and** identify the applicable triggering event in the reason section "Other Change" section in A.
- Eligible for Medicare means the person satisfies the requirements for Medicare but has not yet enrolled for Medicare. Covered under Medicare Parts A or B means you have Medicare and CANNOT enroll for an individual plan.
- You can obtain the providers' correct names and addresses from the appropriate provider directory. You may also obtain each provider's NPI number or PCP ID from the provider directory 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 number or PCP ID. You should confirm the correct NPI number or PCP ID for the specific provider and office location where you will be seen by contacting that office directly.
- For provider addresses, include the zip code plus the four digit extension (9 digits).
- IF YOU HAVE ANY QUESTIONS concerning the benefits and services provided by or excluded under this policy, contact a member services representative at 1-800-877-9829 before signing this form.
- KEEP A COPY OF THIS COMPLETED APPLICATION! A copy of this application may be used as a temporary ID card for 30 days from the effective date if authorized by AmeriHealth New Jersey. Coverage must be verified with AmeriHealth New Jersey prior to visiting with a specialist or admission to a hospital. You may also register on amerihealthexpress.com and print a temporary ID card that is valid for 10 days.
- Triggering Events:
  1. Loss of eligibility for minimum essential coverage but not if lost due to non-payment of premium.
  2. Dependent attained age 26 or 31 and lost coverage.
  3. Marketplace changed your subsidy determination.
  4. Marriage (at least one spouse must have had coverage for at least 1 day within the prior 60 days.)
  5. Birth, adoption or placement for adoption, placement in foster care.
  6. Gained access to New Jersey plans as a result of permanent move to New Jersey (must have had coverage for at least 1 day within the prior 60 days).
  7. Child support order or other court order requiring coverage
  8. Application to NJ FamilyCare submitted during open enrollment period or during a special enrollment period is found ineligible.
  9. Domestic abuse or spousal abandonment necessitating coverage apart from the perpetrator.

     Please note: You must provide evidence of the triggering event with your enrollment form.

Eligibility

A. Eligibility requirements are set forth under the Individual Health Coverage Reform Act of 1992, P.L. 1992, c. 161 (N.J.S.A. 17B:27A-2 et seq.).

B. You MUST be a New Jersey resident which means your primary residence is in New Jersey.

C. You must not be enrolled for Medicare Parts A or B.

D. If application is made for the Catastrophic Plan the following additional requirements apply:
   1. You must be under 30 years old; OR
   2. You must have a notice that you qualify for an exemption with an exemption certificate number (ECN) from the Marketplace. Attach a copy of that notice to your application.

E. The **Annual Open Enrollment Period** is the designated period of time each year during which you may apply for or change coverage for yourself and family members who are currently uninsured or who are covered under another individual plan, or who are covered under a group health plan, group health benefits plan, a governmental plan, a church plan. Your application must be received during the designated Annual Open Enrollment Period. The Open Enrollment Period begins November 1, and continues until December 15. Your application must be signed, dated and mailed during the Annual Open Enrollment Period. The effective date of coverage applied for by December 15, will be January 1, of the immediately following year.

F. A **Special Enrollment Period** that lasts for 60 days follows the Triggering Events. The effective date of a new policy will be no later than the first of the month following receipt of the application. In addition, if the Triggering Event is the loss of eligibility for minimum essential coverage, the Special Enrollment Period includes the 60 days prior to the Triggering Event.

NOTE: If you currently have coverage, the plan for which you are applying must REPLACE the current coverage but you SHOULD NOT terminate it until the new coverage is effective.

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.

AmeriHealth NEW JERSEY

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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 schwetzscht, 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'dęę', t'áá jiik'eh. Hódíílnih kojį' 1-800-275-2583.

Urdu:
توجہ درکارہے: 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 នោះជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

(OVER)

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: civilrightscoordinator@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*.

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