Affiliated Physicians &
Employers Health Plan

A NJ Self-Insured MEWA

BROKER ENROLLMENT CHECKLIST
APEHP MEWA GROUP

GROUP PAPERWORK (MUST BE COMPLETED AND SIGNED)	PAPERWORK RECEIVED
• BINDER CHECK *(First Month's Premium)*	
• BROKER OF RECORD LETTER	
• MEMBERSHIP DOCUMENTATION *(Not Applicable for Medical Groups)* *(EANJ, HOWELL, JACKSON, GREATER MONMOUTH CHAMBER OF COMMERCE)*	
• HEALTH PLAN PARTICIPATION REQUEST/CONTRACT	
• EMPLOYER PLAN SELECTION SHEET	
• EMPLOYER CERTIFICATION *(Only For Small Group 2-50)* *PARTICIPATION REQUIREMENTS:* *(75% Small Group) (50% Large Group)*	
• COMPLETE CENSUS *(Large Groups Only – include enrolling employees, waivers,refusals and part time employees)*	
• WAITING PERIOD INDICATED *(# OF DAYS FOLLOWING THE FIRST OF MONTH, 0,30,60)*	
• REHIRE WAITING PERIOD *(Waive if within 30 days or Treat as New Hire)*	
• PAYROLL VERIFICATION *(Groups 2-50)* *WR 30 ,K1 with 1040, 1120 or 1120S, K1 with 1040 and 1065* **Note: if income on line 7 of the 1040 provide W2 to substanciate*	
• DOCUMENTATION WAIVER *(LARGE GROUP SPREADSHEET ONLY)*	
• FINAL RATE SHEET RATE QUOTE#	
EMPLOYEE PAPERWORK (MUST BE COMPLETED AND SIGNED)	
• EMPLOYEE ENROLLMENT FORMS *(Require Birth Certificate or Marriage Certificate if different last names)*	
• ENROLLMENT SPREADSHEET *(Large Group Only)*	
• WAIVER FORMS *(Include Copy of Current ID Card)*	
COBRA INFORMATION	
• DOES THE EMPLOYER ADMINISTER THEIR OWN COBRA (Y/N)	
• COBRA/DEP 31 MEMBERS APPLICATION AND QUESTIONNAIRE RECEIVED **PLEASE NOTE: COBRA PARTICIPANTS WILL NOT BE ENROLLED UNTIL PAYMENT IS RECEIVED BY OUR COBRA ADMINISTRATOR- OCA*	
CONFIRMATION OF DOCUMENTS	
• BROKER NAME	
• BROKER SIGNATURE	
• SUBMISSION DATE **INCOMPLETE PAPERWORK WILL NOT BE PROCESSED*	

Affiliated Physicians & Employers Health Plan
A NJ Self-Insured MEWA

HEALTH PLAN PARTICIPATION REQUEST / CONTRACT

Please Print

Please send forms to:
Concord Management Resources
P.O. Box 5487
Somerset, NJ 08875
Phone: 833-MEWANOW (833-639-2669)
Fax: 833-MEWAFAX (833-639-2329)
Email: mewaenrollment@concordmgt.com

Section 1: Employer Information

Employer Name: ______________________________

Federal Tax Identification #: ______________________________

To be completed by Trust (Plan Sponsor)

Eligibility	Group #	Account #

____
Address: Street Address Suite City State Zip

Phone: ( ) ____________ Fax: ( ) ____________ E-Mail Address: ____________

Affiliation(s) (If Applicable): ____________ Specialty or Business Type: ____________

Section 2: Billing Information

Billing Address (if different from above): Phone: ( ) ____________ Fax: ( ) ____________

____
Street Address Suite City State Zip

Billing Contact Name: ______________________________

Method of Payment (Check One):

☐ Direct Debit from Bank Account
Please attach a copy of a voided check.

Bank Name: ______________________________

ABA Routing #: ____________ Account #: ____________

☐ Check Remittance

Section 3: Billing & Collections Guidelines

Although the contract period is one year (except as provided in Section 7), payment of the Health Care Fee will be required monthly. The following guidelines will be used for the Billing and Collection of the Health Care Fee:

1. *Bills will be mailed out by the 15th of the month prior to the billing month.*
2. *If paying by check – the remittance will be due on the 1st of every month.*
3. *If paying by Direct Debit – the payment will be deducted on the 1st business day of every month.*
4. *If payment is not received, or moneys are not available for debit from a bank account by the end of the 31-day grace period, all coverage for a Participating Member/Group's covered employees may be terminated retroactive back to the 1st of the month for which payment was due and the Participating Member/Group will be responsible for Health Care Fees due until the earlier of the end of the contract period or by providing the Trust with the proper termination notice as provided for in Section 6.*
5. *Reinstatement will not be permissible for a Participating Member/Group until the next Annual Open Enrollment Period.*
6. *Employee and/or dependent terminations must be sent to the Plan Administrator prior to the termination date. If a termination request is received more than 15 days after the termination date, the employee and/or dependent will not be terminated until the end of the month in which the termination is received and the employer will be responsible for any applicable Health Care Fees. Employers are ultimately responsible for confirming terminations are received by the Plan and should review their bills each month.*
7. *Billing will be based on the current census of employees enrolled in our system. Upon enrollment if quoted membership changes more than 10% from the original quote or if the group's membership changes more than 10% during the year, the Plan reserves the right to requote. The rate structure is subject to change at any time.*

By signing this contract, the applicant understands that failure to pay Health Care Fees in accordance with the "Billing and Collections Guidelines" will result in the termination of this contract and that it will be responsible for Health Care Fees due.

Section 4: Effective Date of Coverage

Effective Date of Coverage: ______________________________.

Please note the date that the applicant wishes coverage to start for eligible employees. This date is contingent upon acceptance of this Participation Request/Contract by the Trust. The applicant will be notified of the acceptance of this request and effective date in writing.

Section 5: Plan Type & Employee Coverage

The applicant requests participation for the following coverage: ☐ **Medical/Rx Only** ☐ **Medical/Rx & Dental**

The applicant requests participation for ____________ employees (enter approximate number of employees, including owners enrolling for coverage). Enrollment material will be provided to the applicant for distribution to eligible employees upon approval of this Participation Request/Contract.

Section 6: Health Care Fees

Exhibit A - **Health Care Fees (rates)** - effective from the Effective Date of Coverage above through ____________ (Initial Contract Period). In addition to changes in rates based on employee ages, rates may be adjusted during the contract period should the claim expense and/or plan utilization exceed projections.

Section 7: Contract Terms & Termination of Contract

Contract Terms: The Renewal Date for this Plan is every ________________ . Renewal Rates will be provided at least 30 days prior to the Renewal Date. Coverage will be automatically renewed for additional one-year (1) contract periods (Renewal Contract Periods) by payment of the applicable Health Care Fee due every ______________ , provided the group continues to meet eligibility requirements. Renewals will be on the same terms and conditions as those in effect for the Initial Contract Period, unless notified otherwise by the Plan.

Termination of Contract: Participating Member's may terminate this Contract upon renewal by providing the Plan Administrator written notice within 15 days from the end of a Renewal Contract Period. Participating Member's may also terminate this Contract at any time by giving the Plan Administrator written notice at least 60 days in advance of termination date. If written notice is not provided 60 days in advance, the Participating Member will be responsible for Health Care Fees that would be due as if proper notice been provided, i.e., for the 60 day period.

By signing this contract, the applicant agrees to pay the Health Care Fees (Exhibit A) as provided in Section 6, based on the census maintained by the Trustees for employees that are eligible for coverage under the benefit plan applied for through the end of the Initial Contract Period and, upon payment of revised Health Care Fees, any Renewal Contract Period. The applicant understands that each Renewal Contract Period will be for additional periods of twelve (12) months and at the Health Care Fees provided by the Trust 30 days prior to the end of each contract period, subject to change as described above.

Section 8: Summary of Benefits and Coverage (SBC)

The Patient Protection and Affordable Care Act has established many new requirements and standards for group health plans, including the requirement to create and distribute a uniform Summary of Benefits and Coverage (SBC). The purpose of the SBC is to provide standard information and uniform language across the health benefits business to allow consumers to easily compare options and select health plans. Members can access SBC's by visiting www.apehp.com. A hard copy of the SBC can also be provided upon request, please call the Plan at (888) 670-8135 for a copy or if you have any questions about the SBCs. For more information regarding this healthcare reform provision, please visit www.healthcare.gov

Section 9: Underwriting Guidelines

Exhibit B - Underwriting Guidelines are in force from the Effective Date of this contract and remain in effect for each subsequent Renewal Contract Period unless written notification is provided by the Trust.

By signing this contract, the applicant agrees to the attached (Exhibit B) underwriting guidelines and understands that should it provide false information or fail to meet the requirements for eligibility that it will result in the termination of this contract for all covered persons.

Section 10: Statement of Contingent Liability

This is a fully assessable benefit plan. In the event that the Trust is unable to pay its obligations, Participating Members in the Trust shall be required to contribute on a pro rata earned contribution basis the funds necessary to meet any unfilled obligations.

Section 11: Participation Request

The applicant requests participation for its employees in the Trust. The applicant also agrees to be bound by all the conditions of participation and further agrees that:

1. *Neither this request to participate, nor the payment of any moneys to be applied towards contributions for coverage, shall cause coverage to become effective on any of the applicant's employees. In order for coverage to go into effect on the date specified by this Contract, the applicant must be accepted as a Participating Member and the applicant's employees must satisfy the applicable eligibility requirements.*
2. *If applicable, the applicant must be a member in good standing with its association when applying for participation in this Trust, must meet membership requirements established by the by-laws of its association and must remain a member in good standing with its association for coverage to stay in effect.*
3. *The applicant has seen a copy of the benefits proposed and agrees to pay the required contributions (Health Care Fees) to the Trustees when due and in accordance with the Billing & Collections Guidelines. The Applicant further agrees to give all eligible employees an opportunity to enroll for coverage, if contributions from employees are required.*
4. *The coverage is subject at all times to the benefit plan applied for, which alone constitutes the contract under which benefits become payable.*

Acceptance of this request is subject to all of the Trustees' requirements, including the provisions of any Administrative Services Agreement between the Trustees and any third party administrator, but only to the extent such provisions apply to rights and/or obligations applicable to employers accepted as Participating Members in the Trust, and the terms of the applicable benefit plan. The Trustees will notify the applicant of the approval or disapproval of this request. A notice of approval will specify the effective date of the applicant's participation in the Trust. If the applicant is accepted as a Participating Member, it will receive the appropriate benefit plan descriptions and material for enrolling its employees.

The applicant hereby requests participation in the Trust and agrees to be bound by its terms and conditions and the terms and conditions of the Administrative Services Agreement mentioned in the prior paragraph (to the extent they apply to Participating Members).

Name of Applicant (Please Print): ________________________________

Signed: ________________________________ **Date:** ______________

Section 12: To be filled out by Trust (Plan Sponsor)

☐ *Applicant has been Accepted and has met all participation requirements. Coverage will become effective as to applicant's eligible employees on ________________, 20 ______.*

☐ *Applicant has been declined and has not met one or all of the participation requirements.*

Signed: ________________________________ **Date:** ______________

Authorized Representative of the Trust

Affiliated Physicians & Employers Health Plan

A NJ Self-Insured MEWA

EMPLOYER CERTIFICATION

Practice Name and Address:	Telephone:	Renewal Date: / /
	Fax:	
	Account #: (if a current customer):	

Please indicate your office's individual waiting period before medical coverage can begin. Select only one for each.

New Hire: __1st of the month following date of hire; __1st of the month following 30 days; __1st of the month following 60 days

Rehire: __ 1st of the month following date of hire; __1st of the month following 30 days; __1st of the month following 60 days

If any class of employee waiting period is waived, please list classes below *(Example: Medical coverage begins immediately for "Physicians – No Waiting Period")*: ____________________

FOR EMPLOYERS WITH MULTIPLE SITES

If you have more than one site (office), other than the address above, please list out your multiple sites and total employees at each site:

Site (Office) Location (City/State)		Number of Employees in each site			
CITY	STATE	Full-time	Part-time	Retired	Other

TOTAL EMPLOYEE CALCULATION

Total Employees

A **Total # Full-Time Eligible Employees* (Refer to Underwriting Guidelines)** ________ **(A)**

B **Total # Part-time Employees (Refer to Underwriting Guidelines)** ________ **(B)**
(does not include Per Diem employees)

C **Total # Employees (A+ B):** ________ **(A+B)**

Total Benefit Eligible Employees *(Based on "A" Total above)*

Total # Eligible Employees applying/enrolling for health benefits coverage. ________

Total # Eligible Employees waiving health benefits coverage with other coverage ________
through a spouse, other than individual coverage; or any other Health Benefits Plan offered by the employer.

Total # Eligible employees waiving health benefits coverage without other coverage ________
through a spouse, other than individual coverage; or any other Health Benefits Plan offered by the employer.

Federal Law – Eligible Employees *(Based on "C" Total above – Includes Part-Time)*

Is your firm subject to the requirements of the federal COBRA law? ☐Yes ☐No
(You *may* be subject to the law if you employed 20 or more employees during 50% or more of the working days during the previous calendar year.)

Is your firm subject to Working Aged Provisions of federal law (TEFRA/DEFRA)? ☐Yes ☐No
(You *may* be subject to the law if you employed 20 or more employees for 20 weeks in the current or prior calendar year.)

* An Eligible Employee as defined in the Underwriting Guidelines.

CERTIFICATION AS A SMALL EMPLOYER (IF APPLICABLE), IN THE STATE OF NEW JERSEY

"Small Employer" means, in connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that:

- employed an average of at least two, but not more than 50, Eligible Employees on business days during the preceding Calendar Year, and
- employs at least two Eligible Employees on the first day of the Plan Year, and
- the majority of the Eligible Employees are employed in New Jersey.

Continue onto back page

If you're total in **part A** on the previous page is **between 2-50**, you qualify as a Small Employer and must check the boxes **D and F** and sign below. If you're total in **part A** on the previous page is **greater than 50 or equal to 1**, check boxes **E and F** and sign below.

D ☐ **I certify that I qualify as a Small Employer in the State of New Jersey.**

OR

E ☐ **I certify that I do not qualify as a Small Employer in the State of New Jersey, based on the previous definition.**

AND

F ☐ **I certify that the information provided the Affiliated Physicians and Employers Health Plan is true and complete.** I understand that if the above information is not complete or is not provided in a timely manner, then health benefits coverage does not have to be offered or continued. I further understand that incomplete or untrue information may void health benefits coverage.

Signature of Officer, Partner or Owner: ______________________ Title:______________ Date:________

Print Name of Officer, Partner or Owner: ______________________________________

Signature of Witness: ______________________________________ Date:________

Any person who includes any false or misleading information on an application or enrollment form or certification for a health benefits plan is subject to criminal and civil penalties, as well as termination of all health coverage.

EMPLOYEE CENSUS INFORMATION

Please include the following persons in the following list:

a) employees, owners, partners, officers, and independent contractors who are actively working for the employer on a regular basis, and are paid by the employer on a regular basis, whether or not they are eligible to be covered.

b) employees, owners, partners, officers, and independent contractors who are not working, but who are currently covered under the employer's health benefits plan for reasons such as continuation of coverage or total disability.

Please use the following letters to indicate Status:

O: Owner, partner or officer
F: Full-time employee
P: Part-time employee
D: Totally Disabled employee
W: Waiving Coverage (has coverage through spouse, Medicare or other source)
I: Independent Contractor
T: Temporary employee
Y: Per Diem employee
C: Continuation of Coverage under State or Federal law
X: Does not want Coverage

Employee Name & Title (Example: John Smith -Doctor)	Date of Birth (mo,dy,yr)	Gender (M,F)	Date of Hire (mo,dy,yr)	Type of coverage (Single, EE/Child(ren), EE/Spouse ,Family)	Hours Worked per week	Status (F,P,D,W,I,T,C,X, Y)
PLEASE ATTACH A COPY OF CURRENT CENSUS TO INCLUDE ALL ELIGIBLE EMPLOYEES, PART TIME AND WAIVERS						

If additional space is needed, attach a separate sheet.

1) Please note that you can offer multiple plans alongside this plan and therefore can request a quote for 1 or 2 or 3 or 5 plans.

Call us if you have any questions at 833-MEWANOW (833-639-2669).

Affiliated Physicians & Employers Health Plan
A NJ Self-Insured MEWA

Please send forms to:
Concord Management Resources
P.O. Box 5487, Somerset, NJ 08875
Phone: 833-MEWANOW (833-639-2669)
Fax: 833-MEWAFAX (833-639-2329)
Email: mewarenewals@concordmgt.com

EMPLOYER HEALTH PLAN RENEWAL INSTRUCTIONS

Step 1: Select your Medical Plan Option - You can select one (1) plan or any combination of the twenty-one (21) medical plan options.
Step 2: Select your Rx Plan Option – You can select multiple Rx plans for each selected medical plan. Specific Rx plans are available with each medical plan.
Step 3: Optional - Select your Dental Option(s) – You can select both Delta Dental and Guardian Dental Options.
Step 4: Optional – Select FSA and HRA, check all that apply. **Step 5: Sign and date.**

Note: Please ensure you fully understand the Plan Benefits you are enrolling in, as you can only change your selection during the Plans Open Enrollment. You must email, fax or mail your renewal paperwork to the Plan no later than the Due Date specified.

EMPLOYER PLAN SELECTION FORM

ACCOUNT #: ______________________ **EFFECTIVE DATE:** ______________
GROUP NAME: ______________________ **PHONE #:** ______________
CONTACT NAME: ______________________ **EMAIL:** ______________

OCA is the COBRA administrator for the Plan. The service is provided at no additional cost to the employer. Please indicate your COBRA Administrator.
OCA: ______ **Other:** ____

Step 1 – Medical Plan Options Please Check All Plans Being Offered	Step 2 – Rx Plan Options Please Circle One (1) or more Rx Option per Plan Offered. If No Rx is selected, medical rates will increase 2%.
❑ Plan A: Open Access POS Network Plan Plus	Plan A Rx Plan: 1 2 3 6
❑ Plan B: Open Access POS Network Plan	Plan B Rx Plan: 1 2 3 6
❑ Plan D: Facility High Deductible Plan	Plan D Rx Plan: 1 2 3 6
❑ Plan F: Network Only High Plan	Plan F Rx Plan: 1 2 3 6
❑ Plan G: Open Access POS Network Plan Basic	Plan G Rx Plan: 1 2 3 6
❑ Plan H: Network Only Base Plan	Plan H Rx Plan: 1 2 3 6
❑ Plan J: Network Only Basic Plan	Plan J Rx Plan: 1 2 3 6
❑ Plan K: Network Only High Deductible Plan	Plan K Rx Plan: 1 2 3 6
❑ Plan L: High Deductible Low Plan	Plan L Rx Plan: 1 2 3 6
❑ Plan M: Community Care Health Plan - Network Only (Gold)	Plan M Rx Plan: 1 2 3 6
❑ Plan N: Community Care Health Plan -High Ded- Network Only(HSA Silver)*	Plan N Rx Plan: 4 5
❑ Plan O: Network Only 70% Plan	Plan O Rx Plan: 1 2 3 6
❑ Plan P: High Deductible 70% Plan	Plan P Rx Plan: 1 2 3 6
❑ Plan R: HSA Compatible*	Plan R Rx Plan: 4 5
❑ Plan S: HSA Compatible High Option*	Plan S Rx Plan: 4 5
❑ Plan T: Network Only Plan	Plan T Rx Plan: 1 2 3 6
❑ Plan U: High Deductible Network Only Plan	Plan U Rx Plan: 1 2 3 6
❑ Plan V: High Deductible Catastrophic Plan	Plan V Rx Plan: 1 2 3 6
❑ Plan W: HSA Compatible Low Option Plan*	Plan W Rx Plan: 4 5
❑ Plan X: Community Care Health Plan - NJ Network Only (Silver)	Plan X Rx Plan: 1 2 3 6
❑ Plan Y: Community Care Health Plan - NJ Network Only (Bronze)	Plan Y Rx Plan: 1 2 3 6

Rx Option 1
Retail: $6/$25/$40
Mail: $15/$62.50/$100

Rx Option 2
Retail: $20/$40/$70
Mail: $50/$100/$175

Rx Option 3
Retail: $15 Generic /50% Brand (Min/Max Apply)
Mail: $37.50 Generic /50% Brand (Min/Max Apply)

Rx Option 4
Member must meet Ded.
Retail: $6/$25/$40
Mail: $15/$62.50/$100

Rx Option 5
Member must meet Ded.
Retail: $15 Generic /50% Brand (Min/Max Apply)
Mail: $37.50 Generic /50% Brand (Min/Max Apply)

Rx Option 6
No Rx Coverage

** These plans may be aligned with a **Health Savings Account** (HSA) **ONLY if you have an RX plan that is applied to the high deductible before benefits are paid.** The AP MEWA does not administer HSA Accounts. If you would like information on where to obtain a HSA Account please contact your Account Exec.*

Step 3 – Dental Plan
The Dental Plan is only offered with enrollment in the medical plan. There is an additional charge for this option.
You can select both Delta Dental and the Guardian Dental Options.

❑ No Dental
❑ Delta Dental Premier
❑ Delta Dental Base PPO
❑ Guardian PPO Dental Plan
❑ Guardian DHMO Dental Plan

***Step 4 – FSA and HRA**
If administered by OCA please indicate below. There is an additional charge for this service.

❑ No HRA/FSA
❑ Flexible Spending Account (FSA)
❑ Health Reimbursement Account (HRA)

*I acknowledge that all my enrolled employees meet all of the Affiliated Physicians and Employers Health Plan Underwriting Guidelines. I further acknowledge that I must provide waivers for all employees waiving coverage and that I must complete all additional renewal requirements, such as providing Wage and Tax information for employees enrolled. **I understand that the elections above override all previous elections and that I am unable to make changes until our next open enrollment.***

*I take full responsibility that the information I am providing, attached to this Renewal Documentation Form, is accurate and represents **all** changes/terminations/additions to my enrolled or eligible members for this renewal period. Any requests or discrepancies that arise after the processing of the attached documents may not be eligible for coverage until the next open enrollment period (for changes/additions). Terminations may not be processed until the next eligible termination date, according to the Plan's Underwriting Guidelines, or if I offer coverage through a Section 125 election, not until the next open enrollment period unless there is a qualifying event.*

**In order to elect FSA and HRA you must contact OCA Benefits to enroll and set up your group. For additional information please contact your Designated Account Executive.*

Please Note: All groups making plan changes must complete this form along with Steps 1-5 in order to renew.

Step 5: EMPLOYER SIGNATURE: ______________________ **DATE:** __________

Affiliated Physicians & Employers Health Plan
A NJ Self-Insured MEWA

Benefit Enrollment Form

for New and Terminated Employees (Members)

Please send forms to:
Concord Management Resources
P.O. Box 5487
Somerset, NJ 08875
Phone: 833-MEWANOW (833-639-2669)
Fax: 833-MEWAFAX (833-639-2329)
Email: mewaenrollment@concordmgt.com

1: Type of Enrollment (Select one option)

(New Groups/Adding a new employee complete this box and all remaining Sections 2-9.)

❑ **New Enrollee**

Effective Date: _______ / _______ / _______

Select Coverage Type:

❑ Single ❑ Parent/Child(ren)
❑ Family ❑ Employee/Spouse
❑ Age 26-31 Dependent Election

❑ **COBRA Election** *Check this box if your current coverage is COBRA or State Continuation and please enter the date your continuation coverage first became effective:*

_______ / _______ / _______

❑ Check If not actively at work when this coverage becomes effective due to Disability, LOA, FMLA, Military Service or other: ____________

(Complete this box for a Qualifying Event and for any change outside of Open Enrollment and complete Sections 2-9.)

❑ **Change in Coverage**

Effective Date: _____ / _____ / _____

Select New Coverage Type:

❑ Single ❑ Parent/Child(ren)
❑ Family ❑ Employee/Spouse

Reason for Change:

❑ Marriage
❑ Birth/Adoption ❑ Dependent Eligibility
❑ Loss of Coverage[1]
❑ Deceased
❑ Part-time to full-time & date__________
❑ Other ____________

(Complete Sections 1, 2 & 3, then date and sign the application in Sections 8 & 9)

❑ **Termination**

Effective Date
Of Termination: _____ / _____ / _____

Reason for termination:

❑ Termination of Employment Voluntary Reason____________
❑ Termination of Employment Involuntary Reason____________
❑ Full-time to part-time
❑ Deceased ❑ Divorce
❑ Other__________

Note: Coverage remains in effect until the end of the month in which notification is received.

2: Employer and Plan Selection Information

Employer's Account #:
(Provided by your employer)

Affiliation____________
Affiliation #____________

Medical Plan Selection:
(Confirm with employer which Plans are offered, ex. Plan A)

Benefit Option(s) Selection: Dental
(Confirm with employer which Benefits are offered, if any.)

Delta: ❑ PREMIER ❑ BASE **Guardian:** ❑ PPO ❑ DHMO

*If electing DHMO provide Dentists PCD#*____________

Rx Option Selection: (Confirm with employer which Rx options are offered, ex. Rx1) ____________

Flexible Spending Account (FSA): ❑ Yes ❑ No

Employer Name: ____________________________

Employer Address: ____________________________
Number & Street City State Zip

3: Employee Demographic Information

Employee Name: ____________________________ ______ - ______ - ______
Last First MI REQUIRED Social Security #

Employee Address: ____________________________
Number & Street (Apartment or Suite) City State Zip

Phone: (_______) ____________ Date of Birth: _____ / _____ / _____ Date of Hire: _____ / _____ / _____

E-Mail Address: ____________________________

Employee Status: ❑ Full-Time ❑ Part-Time Gender: ❑ Female ❑ Male Weekly Hours Worked:_____

4: Dependent Information - List only those dependents to be added or removed from coverage[2]

❑ **Add** ❑ **Remove** the following dependent(s) to my coverage:

	Name	Date of Birth	Gender	REQUIRED Social Security #
Spouse:		_____ / _____ / _____	_____	_____ - _____ - _____
Child:		_____ / _____ / _____	_____	_____ - _____ - _____
Child:		_____ / _____ / _____	_____	_____ - _____ - _____
Child:		_____ / _____ / _____	_____	_____ - _____ - _____

If Domestic Partner ❑check here. If Civil Union Partner ❑check here

Please list additional dependents on a separate sheet of paper.

(1) To Remove an overage dependent, complete Section 1 Change in Coverage, Section 2-3,Section 4 check Remove and list the dependent to be removed, then complete Sections 8 & 9.
(2) To Add or Remove dependent(s), you must complete 2 Enrollment Forms: 1 Form to Add the dependent and 1 Form to Remove the dependent.

Waiver of Dependent Coverage (if none listed above), for dependents eligible under this Plan: *I realize that I can include my dependent(s) on my contract at this time but have chosen to exclude them. I understand that hereafter I may apply for dependent coverage only during an open enrollment period for my Plan or if a qualifying event occurs as defined in the Plan's Summary Plan Description.*

V.11.17

5: Summary of Benefits Coverage (SBC)

The Patient Protection and Affordable Care Act has established many new requirements and standards for group health plans, including the requirement to create and distribute a uniform Summary of Benefits and Coverage (SBC). The purpose of the SBC is to provide standard information and uniform language across the health benefits business to allow consumers to easily compare options and select health plans. Members can access SBC's by visiting **http://apehp.com/forms-documents/**. A hard copy of the SBC can also be provided upon request, please call the Plan at **(888) 670-8135** for a copy or if you have any questions about the SBCs. For more information regarding this healthcare reform provision, please visit **www.healthcare.gov**.

6: Proof of Coverage (Attach to this form)

The Plan reserves the right to request payroll information from you or your employer at any time to ensure that you meet or continue to meet the eligibility requirements of a full-time employee working 24 hours or more. The Plan also reserves the right to request a copy of the following documentation at any time for each eligible dependent: *Spouse- Marriage Certificate or Proof of Domestic Partnership or Civil Union Certificate (if applicable) / Handicapped or Disabled Proof of incapacity verification/ Dependent child(ren) - Birth Certificate, Adoption Papers and/or Legal documentation from the court / Any additional information to verify coverage*

7: Other Insurance / Coordination of Benefits Information

Are you covered under any other group health plan? YES ☐ NO ☐

Are any of your dependents covered by any other group health plan? YES ☐ NO ☐

If yes, complete details of other coverage must be noted in this Section. Otherwise, if you answered NO, please skip to section 8 of this form.

Part A: Divorce/Legally Separated.
Please complete this part if you are divorced or legally separated, and you are applying for dependent coverage under this health plan. Otherwise, continue to Part B.

Date of Divorce/Separation ____________________

Name of Other Biological Parent ____________________ Date of Birth ____________________

*If divorced or legally separated **:*

- ☐ Divorce decree states other parent, ____________________, must provide health benefits.
- ☐ Divorce decree states joint custody with shared responsibility for medical expenses.
- ☐ Divorce decree does not specify parent responsible for medical expenses.
- ☐ Other, please explain ____________________

With what parent does the child(ren) reside? ____________________

***A copy of the section of the court decree pertaining to health coverage would be helpful to support your response.*

Part B: Other Coverage - Non Medicare.
Please complete this section if you or any of your dependents are covered under any other group health plan.

Type of coverage: ____________________ Coverage Effective date: ____________________

Name of Policy holder: ____________________ Name of other Benefit Payer: ____________________

Address of other Benefit Payer: ____________________

List all eligible persons for whom you are applying for coverage under this Plan, who are covered by another plan:

☐ Yourself ☐ Your Spouse ☐ Your Child (ren): List Names ____________________

Name and Address of Spouse's Employer: ____________________

Part C: Medicare Coverage

Person eligible for Medicare ____________________

Medicare #: ____________________ Effective Date of Part A: ____________________ Effective Date of Part B: ____________________

Reason for Medicare Coverage: ☐ Age 65 or older ☐ Disability ☐ ESRD, Date Dialysis Treatment Began: ______ / ______ / ______

8: Application & Authorization

I hereby authorize any physician, hospital, insurer, or other organization or person having any records, data, or information concerning health history or medical insurance/coverage for myself or my eligible family members to furnish such records, data, or information as may be requested by the Plan, or its duly authorized representative. A photocopy of this authorization shall be considered as effective and valid as the original.

I declare that I have read this application in full and that all statements contained in this entire form about me and my dependents are true and correct to the best of my knowledge and that no material information has been withheld or omitted. I understand any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

I hereby apply for coverage on behalf of myself and eligible dependents listed on this form.

I hereby accept responsibility for payment of any portion of the Employee Contribution, if applicable, which I am required to pay, as well as any deductibles, copayments and coinsurance applicable under my Plan. Failure to remit payment will result in the immediate termination of coverage for myself and covered dependents. I further acknowledge that coverage shall become effective only if approved by the Plan Sponsor/Plan Administrator and only for services which are rendered on or after the effective date of coverage.

By providing my e-mail address, I hereby accept electronic delivery of all plan documents to my e-mail address. Plan documents include but are not limited to Health Care Quality Act, HIPAA Privacy Notice, Medicare Part D Notices, Summary Annual Report, Summary of Benefits and Coverage, Summary Plan Description, and Women's Health and Cancer Rights Act. Occasionally, in addition to electronic communications I may also receive a paper copy document. I understand that I can request a paper copy, free of charge, at any time by calling the plan. I can withdraw from the electronic delivery process at any time in the future by calling the plan. I can opt out of the electronic delivery process at this time by checking the box here: ☐

Date ____________________ **Employee Signature:** ____________________

9: To be completed by Employer

I am either the employer or a representative authorized to execute this form.

Employer Representative Signature: ____________________ **Proof of Coverage Satisfied (Check box) :** ☐

Affiliated Physicians & Employers Health Plan

A NJ Self-Insured MEWA

Please send forms to:
Concord Management Resources
P.O. Box 5487
Somerset, NJ 08875
Phone: 833-MEWANOW (833-639-2669)
Fax: 833-MEWAFAX (833-639-2329)
Email: mewaenrollment@concordmgt.com

HEALTH BENEFIT WAIVER

This benefit waiver is available to employees who are regularly scheduled to work a minimum of 24 hours or more every week. Upon renewal of the Group Health Plan, employees may elect to continue to waive out or enroll in the benefit program during the open enrollment period, or at any time upon a qualifying event as defined in the Plan's Summary Plan Description.

WAIVER

I, ______________________________ voluntarily agree to waive coverage under the health benefits offered by______________________________. I understand the above explanation of my rights to waive benefits or enroll in the benefit program offered.

I realize that I can enroll in the group health plan being offered at this time, but have chosen not to participate. I also understand that hereafter I may apply for coverage only during the open enrollment period of the Group Health Plan or if a qualifying event occurs as defined in the Plan's Summary Plan Description.

Choose one of the below options that apply:

_______ I knowingly do not have any type of health (medical, vision & prescription drug) benefits and do not wish to participate in the Group Health Plan being offered.

_______ I certify that I am covered by the following health insurance plan:

Name of Health Insurance Plan:______________________________

Policy Number: ______________________________

Company or Group Sponsor: ______________________________

(Please attach copy of Insurance Card)

____
Employee Signature

____
Date

____
Employer Signature

____
Date

Account #: ____________
To be completed by Plan Administrator

V.AP.11.17