AmeriHealth NEW JERSEY

New business:
Fax to 215-238-2508 or 215-238-2507
Form must be sent with new business submission and tracking cover sheet.

Retention business:
Send to your AmeriHealth New Jersey Account Executive

SEH Group Application

Application for a small group health benefits policy

☐ New Policy ☐ Change in Policy Requested Effective Date:____/____/____

Note: The Effective Date will be on or after the date AmeriHealth New Jersey approves the application.

Please print or type
Policy Number: _____
For AmeriHealth New Jersey use only
AmeriHealth Insurance Company of New Jersey | AmeriHealth HMO, Inc
Group Number:_____

Section I: Policy holder information		
1. Policyholder (full legal name of Company)		
2. Tax Identification Number		
3. **Main Address**		
Street/Apt		
Street/Apt	City	
State	Zip Code	Phone
Email Address	Facsimile	
Main Address		
Street/Apt		
Street/Apt	City	
State	Zip Code	Phone
Email Address	Facsimile	
Contract information should be provided Check one. ☐ electronically ☐ hard copy Correspondent		
4. Type of Organization ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Other (explain)_____		
5. Nature of business (specify)	SIC Code	
6. Number of full-time employees in your company_____ Please Refer to the New Jersey Small Employer Certification for the definition of a full-time employee.		
7. Number of full-time employees to be insured		
8. Class or classes to be excluded		
9. Insurance requested for ☐ Employees Only ☐ Employees and Dependents including Spouse ☐ Employees and Dependents excluding Spouse Should the plan provide coverage for domestic partners as permitted by P.L. 2003, c. 246? ☐ Yes ☐ No If yes, should the plan provide coverage for coverage of children of a covered domestic partner? ☐ Yes ☐ No		
10. Is the employer subject to the requirements of COBRA? ☐ Yes ☐ No		
11. Is the employer subject to the requirements of Medicare as Secondary Payor Rules for eligibility due to age? ☐ Yes ☐ No Is the employer subject to the requirements of Medicare as a Secondary Payor Rules for eligibility due to disability? ☐ Yes ☐ No		
12. Orientation Period ☐ Yes ☐ No		
13. Waiting period before employees become insured (may not exceed 90 days): The ☐ 1st or ☐ 15th of the month following the waiting period of: ☐ 0 days ☐ 30 days ☐ 60 days ☐ exactly 90 days for: ☐ Present Employees_____ ☐ New Employees_____ ☐ Rehired Employees_____		
14. Period for Annual Employee Open Enrollment.		
15. What percentage of the total premium will the employer pay?		
16. Deposit: $_____ Premium Paid: ☐ Monthly ☐ Automatic checking withdrawal Premium will be due as of the effective date. The premium for the first month of coverage must be attached.		
17. Affiliates, subsidiaries or branches (Must be included for purpose of participation)		

Legal Name & Location	Number of full-time employees in this company	Number of full-time employees in this company

SEH Group Application

Section II: Specifications for coverage

New business - Please choose from the plan options below.
Retention business - If renewing into new medical benefits, please choose from the plan options below.
☐ Please check box if only selecting new dental benefits.

All AmeriHealth New Jersey Small Group plans are offered with a calendar year benefit period. Only certain Small Group plans are offered with a plan year benefit period. When selecting an AmeriHealth New Jersey Small Group plan, place a check mark next to your plan of choice to indicate the benefit period option of calendar year or plan year (if applicable).

If additional space is needed, please attach a separate sheet, signed and dated.

Bronze Portfolio		
Calendar Year	**Plan Year**	
☐	☐	EPO HSA Local Value $50/$75
☐	☐	EPO HSA Regional Preferred $50/$75
☐	☐	EPO HSA Tier 1 Advantage $50/$75
☐	☐	EPO HSA AmeriHealth Advantage $25/$50
Silver Portfolio		
Calendar Year	**Plan Year**	
☐	☐	POS Plus Local Value $50/$75
☐	☐	POS Plus Regional Preferred $50/$75
☐	☐	HMO Local Value $50/$75
☐	☐	HMO Regional Preferred $50/$75
☐	☐	EPO HSA Tier 1 Advantage $50/$75
☐	☐	EPO AmeriHealth Advantage $30/$60
☐	☐	EPO Local Value $30/$60/50% Coins
☐	☐	EPO Regional Preferred $30/$60/50% Coins
☐	☐	EPO HSA Local Value 90%/90%
☐	☐	EPO HSA Regional Preferred 90%/90%
☐	☐	EPO HSA Local Value 100%/100%
☐	☐	EPO HSA Regional Preferred 100%/100%
☐	☐	EPO HSA Local Value 80%/80%
☐	☐	EPO HSA Regional Preferred 80%/80%
Gold Portfolio		
Calendar Year	**Plan Year**	
☐	☐	EPO Local Value $30/$50/80% Coins
☐	☐	EPO Regional Preferred $30/$50/80% Coins
☐	☐	EPO National Access $30/$50/80% Coins
☐	☐	HMO Regional Preferred $30/$60, Rx 50%/$125 Max
☐	☐	POS Plus Regional Preferred $30/$60
☐	☐	POS Plus National Access $30/$60
☐	☐	EPO HSA Local Value 100%/100%
☐	☐	EPO HSA Regional Preferred 100%/100%
☐	☐	EPO Tier 1 Advantage $30/$50
☐	☐	EPO AmeriHealth Advantage $10/$20
☐	☐	EPO HSA National Access 90%/90%
Platinum Portfolio		
Calendar Year	**Plan Year**	
☐	☐	HMO Regional Preferred $15/$30
☐	☐	POS Plus Regional Preferred $15/$30
☐	☐	POS Plus National Access $15/$30

AmeriHealth NEW JERSEY

SEH Group Application

AmeriHealth New Jersey SEH Ancillary Plans

Adult Vision Options

☐ $100 allowance ☐ $150 allowance ☐ $180 allowance

Pediatric Dental Options – Required

☐ SEH Pediatric Dental ☐ SEH Pediatric Dental with Adult Preventive ☐ SEH Family Dental

The Patient Protection and Affordable Care Act (PPACA) allows for plans outside of the Small Business Health Options Program (SHOP) to issue coverage without pediatric dental benefits as long as the applicant provides reasonable assurance that an exchange-certified Stand-Alone Dental Plan (SADP) covering the pediatric dental benefits has been purchased elsewhere. To help you meet this requirement, AmeriHealth New Jersey is offering pediatric dental coverage through our SEH Pediatric Dental, SEH Pediatric Dental with Adult Preventive, and SEH Family Dental plans.

☐ Attest to having pediatric dental coverage elsewhere

If you did not select one of the stand-alone pediatric dental plans listed above, we require one of the following options as proof of coverage in order to receive reasonable assurance from you.

☐ Option 1 – Please provide supporting documentation such as:

- Copy of dental policy document, which includes specific reference to coverage of pediatric dental benefit; OR
- Welcome letter from dental carrier, which includes specific reference to coverage of pediatric dental benefit; OR
- Current invoice from dental carrier, which includes specific reference to coverage of pediatric dental benefit;

For new and retention business, please submit supporting documentation to: AHNJdentalattestation@amerihealth.com or fax to 609-662-2630.

☐ Option 2 – Please provide the contact information of your pediatric dental carrier for proof of coverage by completing the section below.

Dental Carrier Name	Dental Product Name
Effective date for current Pediatric Dental coverage	Group Dental Policy Number

Section III: All questions must be answered

1. Is there any Group Health Plan
   - now in force and to be continued? ☐ Yes ☐ No
   - currently being applied for? ☐ Yes ☐ No

   If "Yes" identify the name of the Group Health Plan, give a description of the plan(s) and name of insurance carrier(s)_____

2. Name of present or prior group carrier _____
   a. Effective date of prior coverage ____/____/____
   b. Cancellation/Termination date ____/____/____
   c. Is the coverage applied for in this application replacing other group insurance? ☐ Yes ☐ No
   d. If yes, give reason _____
   e. Plan being replaced_____

3. Are extended benefits provided in case of termination of health benefits? ☐ Yes ☐ No

4. To the best of your knowledge, are there any current or former employees or their eligible dependents whose health insurance is being continued? ☐ Yes ☐ No
   If yes, please provide the following information for each current/former employee or dependent on health continuations.

Name of Employess/Dependent	Date of Birth	Type of Continuation State/ Federal/Extended Benefits	Reason for Termination Disability/Other	Continuation Dates

If additional space is needed, attach a separate sheet, signed and dated.

5. To the best of your knowledge are any employees or dependents presently incapacitated? ☐ Yes ☐ No
   To the best of your knowledge are any dependent children incapable of self-support due to a physical or mental disability? ☐ Yes ☐ No
   Additional space to explain if Items 1, 2 or 3 were answered "Yes". Refer to the question number, and give details including names, where appropriate. _____
   _____
   _____

6. Does the employer participate in an arrangement with a Professional Employer Organization (PEO)? ☐ Yes ☐ No
   Refer to Advisory Bulletin 00-SEH-02 if you need information concerning what constitutes a Professional Employer Organization.

SEH Group Application

Section IV: Agent / Producer Information

Agent/Broker Name

Section V: Signature

It is understood that, except as provided under applicable regulations, no individual shall become insured while not actively at work on a full-time basis, and only full-time employees are eligible (Refer to the definition on the New Jersey Employer Certification). It is further understood that no agent has power on behalf of AmeriHealth HMO, Inc. and AmeriHealth Insurance Company of New Jersey to make or modify any request or application for insurance or to bind AmeriHealth HMO, Inc. and AmeriHealth Insurance Company of New Jersey by making any promise or representation or by giving or receiving any information.

It is further understood that no insurance will be effective unless and until the application is accepted in writing by AmeriHealth HMO, Inc. and/or AmeriHealth Insurance Company of New Jersey. Final rates will be based on enrollment data as of the policy effective date. No contract of insurance is to be implied in any way on the basis of the completion and/or submission of this application.

It is understood that I am responsible to provide AmeriHealth HMO, Inc. and AmeriHealth Insurance Company of New Jersey with timely and accurate information regarding the date of hire for new employees and that the requested effective date of coverage will properly apply any orientation period and waiting period requirements applicable to my plan. It is further understood that any retroactive termination requests must be limited to those for which no premium or contribution has been paid for the termination period by the employee or dependent whose coverage is to be retroactively terminated.

☐ Please read this statement and check to confirm. I confirm that I have received the Summary of Benefits and Coverage (SBC) documents associated with the plan or plans I selected on this application. I confirm I will provide SBCs to plan participants and beneficiaries as required by federal regulations and guidance related to the distribution of the SBC, including the requiring for timing and delivery.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Dated at	Dated on
Print name of Officer, Partner, or Proprietor	Signature of Officer, Partner, or Proprietor
Witness to Signature	

Note: If there are any modifications to the statements and answers given in this application (i.e. crossed out, whited-out, erased, information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.

AmeriHealth NEW JERSEY

AmeriHealth NEW JERSEY

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*.

AmeriHealth NEW JERSEY

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
Email: NJSEH-Cert@amerihealth.com
www.amerihealthnj.com

New Jersey Small Employer Certification

Customer Name			Customer ID or Group Number (if a current customer)
Address of Company			
City	State	Zip	

(For Existing Small Employer Groups in the State of New Jersey OR New Applicants)
The following will be used to determine Small Employer eligibility. Please refer to the definition of "full-time employee" on the next page.

*Total number of full-time employees	
*Total number of full-time employees applying/enrolling for health benefits coverage	
*Total number of full-time employees waiving health benefits coverage under the policy with coverage under their spouse's coverage, other than individual coverage, Medicare, Medicaid, or NJ FamilyCare or Tricare or any other group Health Benefits Plan through a different employer	
*Total number of full-time employees waiving health benefits coverage under the policy with coverage under a Health Benefits Plan issued by another carrier and offered by the small employer	
Please separately list the name(s) of the other carrier(s) and the number of employees covered under each: Carrier Name(s): _____ Number of employee(s): _____	
*Total number of full-time employees waiving health benefits coverage under the policy without coverage under a spouse's coverage, other than individual coverage; Medicare, Medicaid, or NJ FamilyCare or Tricare or any other Health Benefits Plan	
* Total number of full-time employees waiving health benefits coverage under the policy with coverage through an individual health insurance policy offered by another carrier	
*Total number of employees in an ineligible class or classes	
*Is your firm subject to Working Aged Provisions of federal law (TEFRA/DEFRA)? *(You may be subject to the law if you employed 20 or more employees for 20 weeks in the current or prior calendar year)*	☐ Yes ☐ No
*Is your firm subject to the requirements of the federal COBRA law? *(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.)*	☐ Yes ☐ No
*What is the **average** number of employees you employed during the entire **previous calendar year** regardless of whether they were eligible for enrolled for group coverage? *(When answering this question please count any employee for whom your company issues a W-2 and include full-time, part-time and seasonal workers.)*	

New Jersey Small Employer Certification

For purposes of certification as a New Jersey Small Employer, an Employer is considered to be a Small Employer if the Employer satisfies the definition set forth below.

Employee and Small Employer Definitions

The definition of Small Employer counts employees as defined below.

Employee means an employee of the Policyholder. An individual and his or her legal spouse when the business is owned by the individual or by the individual and his or her legal spouse, partners in a partnership, sole proprietors, a 2-percent S corporation shareholder and independent contractors are not employees of the Policyholder.

Small Employer means in connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding Calendar Year and who employs at least 1 employee on the first day of the Plan Year.

All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer.

In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

The following calculation must be used to determine if an employer employs at least 1 but not more than 50 employees.
For purposes of this calculation:

a) Employees working 30 or more hours per week are full-time employees and each full-time employee counts as 1;
b) Employees working fewer than 30 hours per week are part-time and counted as the sum of the hours each part-time employee works per week multiplied by 4 and the product divided by 120 and rounded down to the nearest whole number.

Add the number of full-time employees to the number that results from the part-time employee calculation. If the sum is at least 1 but not more than 50 the employer employs at least 1 but not more than 50 employees.

Please note: Small Employer includes an employer that employs more than 50 full-time employees if the employer's workforce exceeds 50 full-time employees for no more than 120 days during the calendar year and the Employees in excess of 50 who were employed during such 120-day or fewer period were seasonal workers.

Full-Time Employee Definition

The definition of Full-time Employee is used to determine eligibility for coverage under a small employer plan. Full-time employees are counted when determining participation for a small employer.

Full-Time Employee means an employee who works a normal work week of 25 or more hours. Work must be at the Policyholder's regular place of business or at another place to which an employee must travel to perform his or her regular duties for his or her full and normal work hours.

Please note that the above definition of Small Employer considers full-time to be 30 hours per week and that definition of full-time is used solely for determining whether an employer is a Small Employer. For purposes of determining which employees are eligible for insurance under a Small Employer plan and whether the Small Employer meets the participation requirement, full-time is defined as 25 hours per week.

Please note: Full-time employees and any dependents to be covered must live, work or reside in the service area of the Group Health Plan.

AmeriHealth NEW JERSEY

New Jersey Small Employer Certification

CERTIFICATION AS A SMALL EMPLOYER IN THE STATE OF NEW JERSEY IN ACCORDANCE WITH NEW JERSEY STATUTE, CHAPTER 27A OF TITLE 17B

For a Group Health Benefits Plan

Please sign and date appropriate section indicating whether or not you meet the definition of a small employer which is an "either or" definition.

☐ **I certify that I qualify as a Small Employer in the State of New Jersey.**
AND
☐ **I certify that the information provided to AmeriHealth New Jersey is true and complete.** I understand that if the above information is not complete or is not provided to AmeriHealth 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.
☐ I certify that I have obtained and maintain a stand-alone pediatric dental plan for all employees and dependents enrolling for health benefits coverage (If applicable).

Signature of Officer, Partner or Owner Title Date

Print Name of Officer, Partner or Proprietor

Signature of Witness Date

☐ **I certify that I am NOT a Small Employer in the State of New Jersey as defined above.**

Signature of Officer, Partner or Proprietor Title Date

Print Name of Officer, Partner or Proprietor

Signature of Witness Date

Total Average Number of Employess

January 1 through December 31 – What is the average number of employees you employed including any affiliated companies* during the prior calendar year. An employee is any person to whom you issue a W-2. This includes full-time, part-time, and seasonal workers who may or may not have been eligible for your medical plan or covered by AmeriHealth New Jersey. To calculate average number of employees, determine the average number of employees for each month, add each month's number to get an annual total, and then divide by 12. Round to the nearest whole number.
*If the business is aggregated with one or more other businesses and treated as a single employer under subsection (b) controlled group of corporations, (c) partnerships, proprietorships, etc., under common control, (m) employees of an affiliated service group, or (o) other regulations of section 414 of the Internal Revenue Code, then please provide the combined total number of employees for all businesses that are included in the "single employer group" under the Internal Revenue Code.

Month:	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Total	Average divided by 12
FT EE														
PT EE														
Seasonal														
Total														

AmeriHealth NEW JERSEY

New Jersey Small Employer Certification

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.

Group Health Benefits Policy Participation

COMPLETE THIS SECTION **ONLY** IF YOU HAVE CERTIFIED THAT YOU ARE A SMALL EMPLOYER IN THE STATE OF NEW JERSEY.

***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 under the policy.

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 who works 25 or more hours per week
P: Part-time employee who works less than 25 hours per week
C: Continuee under state or federal law
U. Employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement.
S: Seasonal Employee
D: Totally Disabled employee
T: Temporary employee
I: Independent Contractor

If you have listed less than 5 (five) enrolled employees, please include tax documents that show proof of ownership and/or employment for all full-time employees. Acceptable documents include:

- *New Jersey WR-30 – Employer Report of Wages Paid*
- *W-2 (if recent)*
- *W-4 (if needed to verify recent new hire)*
- *Payroll documents showing taxes taken out*
- *Schedule C, Schedule K-1 or Schedule F (for owners only)*

AmeriHealth NEW JERSEY

New Jersey Small Employer Certification

Name	Job Title	Date of Hire	Hours worked per week	Job Status	Work Location (State)	Residence Location (State)	Gender	Date of Birth		
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										

*If additional space is needed, attach a separate sheet.

Please indicate below the number of employees by work location/State. All employees must be included, regardless of whether or not they currently have medical coverage and through whom that coverage is provided.

Work Location (List by State)	Number of Employees				
	Full-time	Part-time	Retired	COBRA or State Continuees	Other

AmeriHealth NEW JERSEY

AmeriHealth NEW JERSEY

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 કૉલ 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*.

AmeriHealth NEW JERSEY

AmeriHealth NEW JERSEY

Please mail to:
AmeriHealth New Jersey
259 Prospect Plains Rd, Building M
Cranbury, NJ 08512

Health Benefits Waiver of Coverage

GROUP NAME	
GROUP POLICY #	
EMPLOYEE NAME (Last, First, MI):	
SOCIAL SECURITY #	
DATE OF BIRTH	____/____/____
DATE OF HIRE	____/____/____
MARITAL STATUS	☐ Single ☐ Married ☐ Widowed ☐ Divorced

I was given the opportunity to enroll in this plan of group health benefits offered by my employer and insured by AmeriHealth New Jersey.

I REFUSE the following:

- ☐ Employee, Spouse and Child(ren) Coverage
- ☐ Spouse Coverage
- ☐ Child(ren) Coverage

Reasons for Refusal (Please indicate all that apply.)

- ☐ other group coverage sponsored by my employer
- ☐ other group coverage sponsored by my spouse's employer
- ☐ other group coverage sponsored by another organization
- ☐ other reasons - please explain: _____

Please provide name of carrier and policy number: _____

I understand that if I later wish to enroll for any of the coverage(s) refused, I will be required to submit an Enrollment Form.

Signature of Employee:

Date: ____/____/____

Signature of Witness:

Date: ____/____/____

AmeriHealth NEW JERSEY

Language Taglines and Nondiscrimination Notice

Language Access Services

This Notice has Important Information. This notice has important information about your application or coverage through AmeriHealth New Jersey. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 1-888-968-7241 TTY 711.

Este aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de AmeriHealth New Jersey. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 1-888-968-7241 TTY 711.

本通知含有您的申请或 AmeriHealth New Jersey 提供的健康保险信息等重要信息。请留意本通知内的重要日期。为了保留您的健康保险或得到收费相关支持，请在截止日期之前采取措施。相关咨询请联系我们为您提供的免费多语言信息服务，1-888-968-7241。

본 알림에는 귀하의 신청 또는 AmeriHealth New Jersey 를 통한 건강 보험과 관련된 정보와 같은 중요한 정보가 포함되어 있습니다. 본 알림에서 중요한 날짜를 확인하십시오. 지정된 마감일까지 조치를 취하셔야 건강 보험을 계속해서 유지하거나 비용 관련 지원을 받으실 수 있습니다. 관련 정보 및 지원은 해당 언어로 무료로 받으실 수 있습니다. 통역사와 상담하시려면 1-888-968-7241 로 전화해 주십시오.

Este aviso contém informações importantes. Este aviso contém informações importantes a respeito do seu formulário de solicitação ou cobertura por meio do AmeriHealth New Jersey. Procure as datas importantes neste aviso. Talvez seja necessário que você tome providências dentro de determinados prazos para manter a cobertura do seu plano de saúde ou ajuda de custos. Você tem o direito de obter esta informação e ajuda em seu idioma e sem custos. Ligue para 1-888-968-7241.

આ સૂચનામાં અગત્યની માહિતી છે. આ સૂચનામાં તમારી અરજી અથવા AmeriHealth New Jersey દ્વારા કવરેજ વિશેની અગત્યની માહિતી છે. આ સૂચનામાંની ખાસ તારીખો જુઓ. તમે તમારા આરોગ્ય કવેરેજ રાખવા અથવા ખર્ચ સાથે મદદ કરવા માટે અમુક ચોક્કસ મુદતો સુધીમાં પગલાં લેવાની જરૂર છે. તમને આ માહિતી અને મદદ તમારી ભાષામાં વિના મૂલ્યે મેળવવાનો અધિકાર છે. અહીં 1-888-968-7241 કોલ કરો.

To ogłoszenie zawiera ważne informacje. To ogłoszenie zawiera ważne informacje dotyczące Państwa wniosku lub zakresu świadczeń udzielanych przez program AmeriHealth New Jersey. Powinni Państwo podjąć działania do czasu upłynięcia wyznaczonych terminów, aby utrzymać swoje ubezpieczenie zdrowotne bądź otrzymać pomoc związaną z kosztami. Mają Państwo prawo do bezpłatnej informacji we własnym języku. Proszę zadzwonić pod numer 1-888-968-7241.

Questo avviso contiene informazioni importanti . Questo avviso contiene informazioni importanti sulla tua domanda o copertura attraverso AmeriHealth New Jersey. Cerca le date importanti in questo avviso. Potrebbe essere necessario un tuo intervento entro certe scadenze determinate per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere gratuitamente queste informazioni e assistenza nella tua lingua. Chiama il numero 1-888-968-7241.

يحوي هذا الإشعار معلومات هامة. يحوي هذا الإشعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خلال AmeriHealth New Jersey. ابحث عن التواريخ الهامة في هذا الإشعار. قد تحتاج لاتخاذ إجراء في تواريخ معينة للحفاظ على تغطيتك الصحية أو للمساعدة في دفع التكاليف. لك الحق في الحصول على المعلومات والمساعدة بلغتك دون أي تكلفة. اتصل بـ 1-888-968-7241.

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Ang Paunawang ito ay may Mahalagang Impormasyon. Ang paunawang ito ay may mahalagang impormasyon tungkol sa iyong aplikasyon o saklaw sa pamamagitan ng AmeriHealth New Jersey. Tingnan ang mahahalagang petsa sa paunawang ito. Maaaring kailanganin mo na magsagawa ng hakbang bago ang mga tiyak na takdang panahon upang mapanatili ang iyong saklaw pangkalusugan o tulong sa mga gastos. May karapatan kang makakuha ng impormasyon at tulong na ito sa iyong wika nang walang gastos. Tumawag sa 1-888-968-7241.

Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через программу AmeriHealth New Jersey. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры до наступления определенных предельных сроков для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 1-888-968-7241.

Avi sa a gen Enfòmasyon Enpòtan ladan. Avi sa a gen enfòmasyon enpòtan konsènan aplikasyon ou, oswa pwoteksyon asirans ou nan AmeriHealth New Jersey. Chèche dat kle yo ki nan avi sa a. Ou kapab bezwen aji avan sèten delè pou kontinye genyen pwoteksyon asirans sante ou oswa resevwa èd gratis. Ou gen dwa pou jwenn enfòmasyon sa a ak èd ou bezwen nan lang ou gratis. Rele 1-888-968-7241.

इस नोटिस में महत्वपूर्ण जानकारी है। इस नोटिस में आपके आवेदन या AmeriHealth New Jersey के माध्यम से बीमे के बारे में महत्वपूर्ण जानकारी है। इस नोटिस में मुख्य तारीखें देखें। अपना स्वास्थ्य बीमा बनाए रखने या लागतों में मदद के लिए आपको कुछ निश्चित समयसीमाओं तक कार्रवाई करने की ज़रूरत हो सकती है। आपको यह जानकारी और सहायता अपनी भाषा में मुफ्त प्राप्त करने का अधिकार है। 1-888-968-7241 पर कॉल करें।

Thông báo này có Thông Tin Quan Trọng. Thông báo này có thông tin quan trọng về đơn xin hoặc bảo hiểm thông qua AmeriHealth New Jersey. Hãy tìm những ngày quan trọng trong thông báo này. Quý vị có thể cần thực hiện hành động trước một số thời hạn để duy trì bảo hiểm y tế hoặc trợ giúp về chi phí. Quý vị có quyền nhận được thông tin và trợ giúp bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Hãy gọi số 1-888-968-7241.

Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou l’assurance médicale fournie par AmeriHealth New Jersey. Recherchez les dates clés dans le présent avis. Vous devez peut-être agir dans des délais spécifiques pour maintenir votre assurance médicale ou pour l'aide avec les coûts. Vous avez le droit d'obtenir gratuitement cette information et de l’aide dans votre langue. Appelez 1-888-968-7241.

اس نوٹس میں اہم معلومات ہیں۔ اس نوٹس میں آپ کی درخواست اور AmeriHealth New Jersey کے ذریعے احاطہ کردہ خدمات کے بارے میں اہم معلومات ہیں۔ اس نوٹس میں اہم تاریخوں پر دھیان دیں۔ آپ کو اپنے طبی تحفظ کو برقرار رکھنے یا اخراجات کے حوالے سے مدد کے لئے کچھ ڈیڈلائنوں کے اندر کاروائی کرنے کی ضرورت ہو سکتی ہے۔ آپ کو بلا معاوضہ اپنی زبان میں یہ معلومات اور مدد حاصل کرنے کا حق ہے۔ 1-888-968-7241 پر کال کریں۔

Díí saad ílínii baa hane’. Naaltsoos ni’íníłtsoozígíí éí doodago kwe’é AmeriHealth New Jersey nik’é’ésti’ígíí bína’ídółkidgo díí kwe’é hazhó’ó baa ákonínízin dooleeł. Yoołkáał yę́édą́ą’ nich’į’ é’élyaago biká’ígíí hádídíí’įįł. Díí niké’ésti’ígíí éí doodago béeso da bee níká a’doowołígíí bikáa’go da áat’ée dooleeł áko t’áadoo bee e’e’aahí baa yółkaahgo tsxíįłgo hasht’e díílíił nii da dooleeł.Bee ná ahóót’i’díí kót’éego yaa halne’ígíí bee níká a’doowołgo dóó t’áá nizaadk’ehjí bee nił hodoonih t’áadoo bą́ą́h ílíní. Kojį’ hodíílnih 1-888-968-7241.

この通知には、AmeriHealth New Jersey の申請や補償範囲に関するとても重要な情報が含まれています。ここに記載されている重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期限までに行動を取る必要があります。お客様は、無料でご希望の言語でのサポートや情報を入手することができます。
ぜひ 1-888-968-7241 までお電話ください。

AmeriHealth NEW JERSEY

Diese Bekanntmachung enthält wichtige Informationen. Diese Bekanntmachung enthält wichtige Informationen über Ihren Antrag bei oder Ihren Krankenversicherungsschutz durch AmeriHealth New Jersey. Beachten Sie bitte die wichtigsten Termine in dieser Bekanntmachung. Sie müssen eventuell vor bestimmten Stichtagen Maßnahmen ergreifen, um Ihren Krankenversicherungsschutz nicht zu verlieren oder finanzielle Unterstützung für diese Leistungen zu erhalten. Sie sind berechtigt, kostenlos Hilfe und weitere Informationen in Ihrer Sprache anzufordern. Bitte rufen Sie uns unter der Nummer 1-888-968-7241 an.

این اطلاعیه حاوی اطلاعاتی مهمی است. این اطلاعیه حاوی اطلاعات مهمی درباره درخواست شما یا قرارگیری تحت پوشش AmeriHealth New Jersey می باشد. به تاریخ های مهم مندرج در این اطلاعیه توجه نمایید. ممکن است لازم باشد به منظور ادامه استفاده از پوشش خدمات سلامت یا کمک در رابطه با کاهش هزینه ها، اقدامات مربوطه را تا قبل از تاریخ خاصی صورت دهید. این حق برای شما محفوظ است که بدون نیاز به پرداخت هر نوع هزینه، اطلاعات مربوطه را به زبان خود دریافت نمایید. با شماره 1-888-968-7241 تماس بگیرید

Nondiscrimination Notice & Notice of Availability of Auxiliary Aids & Services

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

AmeriHealth New Jersey:

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

If you need these services, contact our Civil Rights Coordinator. If you believe that AmeriHealth New Jersey has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, yo can file a grievance with our Civil Rights Coordinator. You have four ways to file a grievance:

- By mail :
  AmeriHealth New Jersey
  Attn: Civil Rights Coordinator
  1901 Market Street
  Philadelphia, PA 19103
- By phone: 888-377-3933 (TTY:711)
- By fax: 215-761-0245
- By email: CivilRightsCoordinator@amerihealth.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.j* 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*.

AmeriHealth NEW JERSEY

AmeriHealth NEW JERSEY

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

Small Group Member Coverage Application

AmeriHealth New Jersey	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. *Refer to instructions before completing this form. Print clearly.*

	Activity – Check all that apply	Date of Event	Date of Hire/Reason for Change
Add	☐ Enrollment of a new Subscriber		
	☐ Add Spouse		
	☐ Add Civil Union Partner		
	☐ Add Domestic Partner		
	☐ Add Dependent Child		
	☐ Add Over-Age Child as a Dependent Under 31 *(and complete Coverage Continuation section)*		
Remove	☐ Employee Withdrawal/Termination		
	☐ Remove Subscriber		
	☐ Remove Spouse		
	☐ Remove Civil Union Partner		
	☐ Remove Domestic Partner		
	☐ Remove Dependent Child		
	☐ Remove Over-Age Child as a Dependent Under 31		
Other changes	☐ Name Change		
	☐ Change Plan		
	☐ Other		
	☐ Add/Change Office ID Numbers: Primary/OB/Gyn/Dentist **See list of Triggering Events in Instructions*		

Coverage continuation						
	☐ For Employee	☐ Total Disability* ☐ COBRA/NJSGC	Length of Continuation (in months): ☐ 18 ☐ 29	Date of Loss of Coverage:	Qualifying Event #: **	Date of Qualifying Event:
	Billing: ☐ Group ☐ Home (Section B)					***Attach proof of disability**
	☐ For Spouse/Civil Union Partner*	Length of Continuation (in months): ☐ 18 ☐ 36	Date of Loss of Coverage:	Qualifying Event #: **	Date of Qualifying Event:	
	Billing: ☐ Group ☐ Home (what address?) ☐ Section B OR ☐ Section E			***Civil union partners are eligible to make an election pursuant to NJSGC, if applicable.**		
	☐ For Dependent/ Over-age Child	☐ COBRA/NJSGC	Length of Continuation (in months): ☐ 18 ☐ 36	Date of Loss of Coverage:	Qualifying Event #: **	Date of Qualifying Event:
	☐ Dependent Under 31	Qualifying Event #: **	Billing: ☐ Group ☐ Home (what address?) ☐ Section B OR ☐ 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: ☐ M ☐ 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: _____

Small Group Member Coverage Application

Activity	☐ Add ☐ Remove ☐ Continuation ☐ Other Change – *If a name change, indicate prior name:*		
	Primary Loc #:	NPI or PCP ID #:	Current Patient: ☐ Yes ☐ No
	Address:		Zip+4:
	Ob/Gyn Loc #:	NPI or PCP ID #:	Current Patient: ☐ Yes ☐ No
	Address:		Zip+4:
	Dentist Loc #:	NPI or PCP ID #:	Current Patient: ☐ Yes ☐ No
	Address:		Zip+4:

Other Health Coverage? ☐ Yes ☐ No If yes: Payer Name: _____ Policy #: _____ Medicare ID#, if any: _____	Other Rx Coverage? ☐ Yes ☐ 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 – *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	Address	Address	Address
Zip+4	Zip+4	Zip+4	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	Address	Address	Address
Zip+4	Zip+4	Zip+4	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	Address	Address	Address
Zip+4	Zip+4	Zip+4	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*

Small Group Member 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 – 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:

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:

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:
Representative's Title:	

AmeriHealth NEW JERSEY

Small Group Member Coverage Application

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

åCOBRA 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.

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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