AmeriHealth NEW JERSEY

**Please Mail To:**
AmeriHealth Insurance Company
259 Prospect Plains Road, Building M, 2nd Floor
Cranbury, NJ 08512

# Instructions for completing the HINT application and verification of requirements form

Initial requests for coverage will require completion of both the HINT application and the verification of requirements form. An updated verification will be required annually, but if there is no break in coverage, only the verification will be required in subsequent years.

To qualify for coverage, the adult child must meet **all** of the eligibility criteria as either a dependent or a student:

**As a dependent, the adult child must:**

– must be a qualified dependent by blood or law of a covered employee/parent/subscriber;
– have a parent/subscriber who is covered under an AmeriHealth New Jersey plan;
– be under age 31;
– not be otherwise eligible for coverage within the plan's limiting age provisions;
– be unmarried or not entered into a civil union;
– have no dependent of his/her own;
– have proof of prior creditable coverage;
– be a resident of the State of New Jersey.

**As a student, the adult child must in addition to above:**

– be enrolled as a full-time student at an accredited public or private institution of higher education (Note: Although the parent/subscriber must be covered under an AmeriHealth New Jersey plan, the student need not reside in New Jersey);
– not receive coverage as a named subscriber, insured, enrollee or covered person under any other group health benefits plan or be entitled to benefits under Title XVIII of the Social Security Act, Pub.L. 89-97.

If the dependent is a full-time student residing out of state, the member must provide:

– the name of the school _____ ;
– the expected date of graduation _____ (mm/yyyy);
– a copy of the class schedule signed and stamped by the registrar.

In addition, please note the following:

– If the over-age dependent has not yet aged-out of his or her parent's group health benefits plan, he or she will have an opportunity to make the election within 30 days BEFORE he or she is scheduled to age-out of the coverage. If the over-age dependent has aged-out, he or she can make an election at any time, only if all the requirements are met.

– Please sign and date the application and verification. Failure to do so will delay processing of your application and coverage will not be activated during such time. Please be sure all questions have been answered, or we will not be able to process your application.

– For each eligible over-age dependent, the AmeriHealth New Jersey premium rate* will be calculated at 100%** of the single rate for the same plan of benefits in which the parent is actively enrolled. Please contact your AmeriHealth New Jersey Marketing Representative for the exact over-age dependent rate. An over-age dependent must include a check for this amount when he or she mails in the completed HINT application. AmeriHealth New Jersey will bill the over-age dependent directly. Ongoing premium payment must be received within 30 days of the due date, or coverage will automatically be terminated.

Note: Although the parent must continue eligibility under the AmeriHealth New Jersey plan for a dependent's coverage to continue, coverage for the dependent will be issued as stand-alone coverage. All cost-sharing requirements and limitations will apply to the dependent only and will not be combined with the parent's policy. Covered expenses incurred by the dependent will not contribute to family deductibles and/or out-of-pocket maximums.

*This premium rate includes the 102% factor that is noted on the HINT application.

** The AmeriHealth New Jersey premium rate for Large Group employers will still be calculated as 67.4% of the single rate for the same plan of benefits in which the parent is actively enrolled.

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# Verification of requirements

The AmeriHealth New Jersey contract states that a dependent may be covered to age 31 if he or she meets certain criteria:

– the dependent's parent remains covered by the plan;
– the employer retains coverage with AmeriHealth New Jersey;
– contributions are made by the dependent.

To request continued coverage, a verification of requirements form must be completed indicating that all of the criteria have been met.

For each eligible over-age dependent, the AmeriHealth New Jersey premium rate* will be calculated at 100%** of the single rate for the same plan of benefits in which the parent is actively enrolled. Please contact your AmeriHealth New Jersey Marketing Representative for the exact rate for over-age dependents. An over-age dependent must include a check for this amount when he or she mails in the completed HINT application. AmeriHealth New Jersey will bill the over-age dependent directly. Ongoing premium payment must be received within 30 days of the due date or, coverage will automatically be terminated.

Note: Although the parent must continue eligibility under the AmeriHealth New Jersey plan for coverage of the dependent to continue, coverage for the dependent will be issued as stand-alone coverage. This means that all cost-sharing requirements and limitations will apply to the dependent only and will not be combined with the parent's policy. Covered expenses incurred by the dependent will not contribute to family deductibles and out-of-pocket maximums, nor will family-incurred expenses contribute to dependent's deductibles or out-of-pocket maximums.

If the dependent meets the qualifications outlined in this verification, please complete, sign and return it within 30 days of your receipt along with a HINT application. A separate HINT application and verification of requirements form must be completed for each dependent.

Covered parent/Subscriber name: _____ Identifier number: _____
Dependent name : _____ Dependent SSN: _____
Group number: _____ Date of birth: _____ (mm/dd/yyyy) Phone number: _____
I, the dependent listed above: (please check all that apply):

☐ am under age 31
☐ am unmarried or not entered into a civil union
☐ have no dependent of my own
☐ have proof of prior creditable coverage
☐ am a resident of the State of New Jersey

or

☐ am a resident of the State of New Jersey, but am enrolled as a full-time student at an accredited public or private institution of higher education.
  – Name of the school _____
  – Expected date of graduation _____ (mm/yyyy)
    Please provide a copy of the class schedule signed and stamped by the registrar.
☐ am not provided coverage as a named subscriber, insured, enrollee or covered person under any other group health benefits plan, nor am I entitled to benefits under Title XVIII of the Social Security Act, Pub.L. 89-97.

By signing below, I confirm that the information I have provided is true, accurate, and current.

Signature of dependent: _____ Date:_____

Please mail this completed form to the following address within 30 days of receipt:
**Mail form and first month's premium check to:**
**AmeriHealth New Jersey, Attn: Sales-OAD, 259 Prospect Plains Road, Bldg. M, Cranbury, NJ 08512**

PLEASE DO NOT SEND THIS FORM TO ENROLLMENT.

*The premium rate includes the 102% factor that is noted on the HINT application.

** The AmeriHealth New Jersey premium rate for Large Group employers will still be calculated as 67.4% of the single rate for the same plan of benefits in which the parent is actively enrolled.

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# HINT Supplemental Enrollment Information Form Implementing

## A. GROUP & EMPLOYEE INFORMATION

Group Name:

Group Number:

Employee Name:

Employee ID Number:

2. Date dependent was last treated:_____

## B. TYPE OF ACTIVITY (SEE IMPORTANT EXPLANATORY INFORMATION BELOW)

Date of Event Change – Check all that apply

☐ Add dependent over the limiting age, but less than 31 ____/____/____

☐ Remove dependent over the limiting age, but less than 31 ____/____/____

Reason(s):_____

_____

_____

☐ Continuation of Coverage pursuant to the Dependent Under 31 Law

Coverage is being effected:

☐ Within 30 days prior to attainment of limiting age

☐ During continuous open enrollment with proof of prior creditable coverage or receipt of benefits (see C. below)

Billing:

☐ Direct bill dependent (add billing address):_____

## C. OVER-AGE DEPENDENT INFORMATION

| | | | |
|---|---|---|---|
| Name (last, first, MI): | Sex: ☐ M ☐ F | Birthdate: (MM, DD, YY)____/____/____ | SSN: |
| Other Health Coverage: ☐ Yes ☐ No | Primary Ofc NPI#: | | |
| Primary Ofc Address [or LOC #]: | | Current Patient: ☐ Yes ☐ No | |
| Other Rx Drug Coverage: ☐ Yes ☐ No | Ob/Gyn Ofc NPI#: | | |
| Ob/Gyn Ofc Address [or LOC#]: | | Current Patient: ☐ Yes ☐ No ☐ N/A | |

Previous Coverage: ☐ Yes ☐ No

If yes, provide the following information AND submit a copy of the certificate of Creditable Coverage that was issued by the previous carrier, if available, OR other evidence of receipt of benefits:

Effective date of prior coverage: ____/____/____

Termination date of prior coverage: ____/____/____

Name of carrier, self-funded employer/employee organization or government program:_____

Prior plan number or ID number: _____

## D. SIGNATURE

| | |
|---|---|
| Employee: | Dependent |
| Date: | Date: |
| Employer Consent to Payroll Deduction: ☐ Yes ☐ No | |
| Name & Title: | Date: |

# HINT Supplemental Enrollment Information Form Implementing

**IMPORTANT INFORMATION FOR THE DEPENDENT UNDER 31 ELECTION**

A young adult may request to continue or newly enroll as an over-age dependent on his or her parent's coverage after reaching the limiting age under the terms of the policy if the young adult:

- ✔ is not yet 31 years old;
- ✔ is unmarried;
- ✔ has no children;
- ✔ lives in New Jersey or, if not a New Jersey resident, is a full-time student at an accredited institution of higher education;
- ✔ is not eligible for Medicare and would not actually be covered under another group or individual health plan when coverage would become effective; and
- ✔ has proof of prior creditable coverage or receipt of benefits.

A young adult may make the request to continue or newly enroll as an over-age dependent on his or her parent's coverage either:

- ✔ within 30 days prior to reaching the limiting age, if the young adult is covered under the parent's policy already; or
- ✔ at any time after reaching the limiting age of the parent's policy, and otherwise meeting the eligibility requirements for the Dependent Under 31 election.



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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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