AmeriHealth NEW JERSEY

Large Group Enrollment

For all new Large groups:

- This completed Group Enrollment Form
- Copy or signed Rate Quote
- Enrollment form for each enrolling employee (Note: Product selection by subscriber is required)
- First month's premium – MUST BE CORPORATE CHECK (not personal)
- Broker of Record letter, on enrolling company's letterhead
- Waivers, if applicable

Group enrollment information	
Group Name:	Executive contact/Email address:
Address:	Group Admin/Email address:
City/State/ZIP:	Billing contact/Email address:
Phone:	Industry/NAICS code:
Effective date:	Total number of employees:
Tax ID: :	Total eligible employees:
Check amount: Total eligible employee	Total enrolled employees:
Prior carrier:	Total employees waiving coverage:

Plan selections		
Medical	**Prescription drug**	**Vision**

To view the Summary of Benefits and Coverage (SBC) for your plans, visit **amerihealthexpress.com** or call **1-888-YOUR-AH1 (1-888-968-7241)** to request a paper copy.

☐ Confirm receipt of SBC

By signing, I acknowledge that I have completed all documents required by AmeriHealth New Jersey, and that if any required documentation is not included with this submission, the entire case will be returned to me.

Producer signature

General agent