



Individual Coverage Application

Please mail to:
 AmeriHealth New Jersey
 PO Box 8240
 Philadelphia, PA 19101-9250
 Tel 609-662-2400

A. Type of Activity – To be completed by Applicant. *Refer to instructions before completing this form. Print clearly.*

| | Activity – Check all that apply | Date of Event | Reason |
|----------------------|--------------------------------------------------------|---------------|--------|
| Add | Enrollment of a new Subscriber | | |
| | Add Spouse | | |
| | Add Civil Union Partner | | |
| | Add Domestic Partner | | |
| | Add Dependent Child | | |
| Remove | Remove Subscriber | | |
| | Remove Spouse | | |
| | Remove Civil Union Partner | | |
| | Remove Domestic Partner | | |
| | Remove Dependent Child | | |
| Other Changes | Name Change | | |
| | Change Plan | | |
| | Special Enrollment Period (due to a Triggering Event*) | | |
| | Other | | |
| | Add/Change Office ID Numbers: Primary/OB/Gyn/Dentist | | |

*See list of Triggering Events in instructions. Provide evidence of triggering event with the enrollment form

B. Applicant Information

| | | |
|------------------------|-----|------------------------|
| Name (Last, First, MI) | SSN | Birthdate (mm/dd/yyyy) |
|------------------------|-----|------------------------|

Email

By providing an email address you consent to receive information, including the policy, by electronic means.

| | | |
|------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Male <input type="checkbox"/> Female | Are you a resident of New Jersey? <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you maintain a home in any other state or country? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | If yes to the above , name of state/country | |
| | Number of months you live there each year | |

| | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|----------|-------|
| Address Information | Primary Residence | | |
| | Street/Apt | | |
| | Street/Apt | City | |
| | State | Zip Code | Phone |
| | Other Residence | | |
| | Street/Apt | | |
| | Street/Apt | City | |
| | State | Zip Code | Phone |
| Your billing address: <input type="checkbox"/> Primary residence <input type="checkbox"/> Other residence <input type="checkbox"/> P.O. Box or Other (<i>specify</i>) | | | |
| Mailing address (for communications other than bills: <input type="checkbox"/> Primary residence <input type="checkbox"/> Other residence <input type="checkbox"/> P.O. Box or Other (<i>specify</i>)) | | | |

| | | | |
|-----------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|---------------------------------------------------------------------------|
| Activity | <input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Other Change <input type="checkbox"/> Continue <i>If a name change, indicate prior name:</i> | | |
| | Primary Loc # | NPI or PCP ID # | |
| | Address | Zip +4 | Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Ob/Gyn Loc # | NPI or PCP ID # | |
| | Address | Zip +4 | Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Dentist Loc # | NPI or PCP ID # | |
| Address | Zip +4 | Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No | |

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



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C. Medical Plan Options:

Catastrophic Portfolio

| Select Plan | |
|--------------------------|--------------------------|
| <input type="checkbox"/> | Local Value Simple Saver |

Bronze Portfolio

| | |
|--------------------------|--------------------------------------------------|
| <input type="checkbox"/> | EPO HSA AmeriHealth Advantage \$25/\$50 |
| <input type="checkbox"/> | EPO HSA AmeriHealth Hospital Advantage \$50/\$75 |
| <input type="checkbox"/> | EPO HSA Local Value 50%/50% |
| <input type="checkbox"/> | EPO Local Value \$50/\$75 |

Silver Portfolio

| | |
|--------------------------|---------------------------------------------------------|
| <input type="checkbox"/> | SELECT EPO AmeriHealth Advantage \$25/\$60 |
| <input type="checkbox"/> | SELECT EPO HSA AmeriHealth Hospital Advantage \$50/\$75 |
| <input type="checkbox"/> | SELECT HMO Local Value \$50/\$75 |
| <input type="checkbox"/> | EPO AmeriHealth Advantage \$25/\$60 |
| <input type="checkbox"/> | EPO HSA AmeriHealth Hospital Advantage \$50/\$75 |
| <input type="checkbox"/> | HMO Local Value \$50/\$75 |
| <input type="checkbox"/> | HMO Regional Preferred \$50/\$75 |
| <input type="checkbox"/> | EPO HSA Local Value \$50/\$75 |
| <input type="checkbox"/> | EPO Regional Preferred \$50/\$75 |

Gold Portfolio

| | |
|--------------------------|----------------------------------|
| <input type="checkbox"/> | HMO Regional Preferred \$20/\$50 |
| <input type="checkbox"/> | EPO Regional Preferred \$30/\$50 |

AmeriHealth New Jersey Ancillary Plans

Pediatric Dental Options

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

Adult Vision Options

Adult Vision Care \$100/ \$150 Adult Vision Care \$130/ \$180 Adult Vision Care \$150/ \$200



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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 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Other | <input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Other | <input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Other | <input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> 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) |
| <input type="checkbox"/> Male <input type="checkbox"/> Female | <input type="checkbox"/> Male <input type="checkbox"/> Female | <input type="checkbox"/> Male <input type="checkbox"/> Female | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| SSN | SSN | SSN | SSN |
| Eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No Covered under Medicare Parts A or B? <input type="checkbox"/> Yes <input type="checkbox"/> No Covered under any health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No | Eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No Covered under Medicare Parts A or B? <input type="checkbox"/> Yes <input type="checkbox"/> No Covered under any health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No | Eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No Covered under Medicare Parts A or B? <input type="checkbox"/> Yes <input type="checkbox"/> No Covered under any health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No | Eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No Covered under Medicare Parts A or B? <input type="checkbox"/> Yes <input type="checkbox"/> No Covered under any health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Primary Care Provider | Primary Care Provider | Primary Care Provider | Primary Care Provider |
| NPI or PCP ID # | NPI or PCP ID # | NPI or PCP ID # | NPI or PCP ID # |
| Address _____ _____ | Address _____ _____ | Address _____ _____ | Address _____ _____ |
| Zip+4 _____ | Zip+4 _____ | Zip+4 _____ | Zip+4 _____ |
| Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No | Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No | Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No | Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ob/Gyn Office | Ob/Gyn Office | Ob/Gyn Office | Ob/Gyn Office |
| NPI or PCP ID # | NPI or PCP ID # | NPI or PCP ID # | NPI or PCP ID # |
| Address _____ _____ | Address _____ _____ | Address _____ _____ | Address _____ _____ |
| Zip+4 _____ | Zip+4 _____ | Zip+4 _____ | Zip+4 _____ |
| Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No | Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No | Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No | Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dentist Office | Dentist Office | Dentist Office | Dentist Office |
| NPI or PCP ID # | NPI or PCP ID # | NPI or PCP ID # | NPI or PCP ID # |
| Address _____ _____ | Address _____ _____ | Address _____ _____ | Address _____ _____ |
| Zip+4 _____ | Zip+4 _____ | Zip+4 _____ | Zip+4 _____ |
| Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No | Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No | Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No | Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If NO, complete Section E</i> | Home address same as Applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If NO, complete Section E</i> | Home address same as Applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If NO, complete Section E</i> | Home address same as Applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If NO, complete Section E</i> |



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E. Additional Spouse / Civil Union Partner / Domestic Partner Information – If not applicable, please mark as "NA."

| | | | |
|------------|-------|----------|------------------------------------------------------------------|
| Street/Apt | | | b. Please explain why the address is different _____ _____ |
| Street/Apt | | | |
| City | State | Zip Code | |

F. Additional Child Information – Provide information below about children listed in Section D, if they have a different address. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.

| | | | |
|------------|--|----------|-------|
| Name(s) | | | |
| Street/Apt | | | |
| Street/Apt | | City | |
| State | | Zip Code | Phone |
| Reason | | | |
| Name(s) | | | |
| Street/Apt | | | |
| Street/Apt | | City | |
| State | | Zip Code | Phone |
| Reason | | | |

G. Race / Ethnicity – Response is appreciated but NOT required!

Choose a category that most closely describes you American Indian or Alaskan Native Black, not of Hispanic origin Hispanic
 Asian or Pacific Islander White, not of Hispanic origin

H. Payment Information – Indicate how you would like to be billed and make payment.

Check Credit Card/Debit Card (first payment only) Pre-paid Debit Card
 Credit or Debit Card Type: American Express Discover Mastercard Visa

| | | |
|--------------------------|------------------|----------------|
| Credit or Debit Card No: | Expiration Date: | Security Code: |
| Cardholder Name: | | |

I. Applicant's Signature

I represent that all the information supplied in this application is true and complete.
 I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form.

| | |
|-----------|------|
| Signature | Date |
|-----------|------|

J. Broker/General Agent Signature

| | | |
|-----------------------|------------|------------------------------------------------|
| Signature of Preparer | Date | <input type="checkbox"/> NJ Producer License # |
| | | <input type="checkbox"/> NPN |
| General Agent | Agent ID # | |



Individual Coverage Application

Instructions and Eligibility Requirements

Instructions

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

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

Eligibility

- A. Eligibility requirements are set forth under the Individual Health Coverage Reform Act of 1992, P.L. 1992, c. 161 (N.J.S.A. 17B:27A-2 et seq.).
- B. You **MUST** be a New Jersey resident which means your primary residence is in New Jersey.
- C. You must not be enrolled for Medicare Parts A or B.
- D. If application is made for the Catastrophic Plan the following additional requirements apply:
 1. You must be under 30 years old; OR
 2. You must have a notice that you qualify for an exemption with an exemption certificate number (ECN) from the Marketplace. Attach a copy of that notice to your application.
- E. The **Annual Open Enrollment Period** is the designated period of time each year during which you may apply for or change coverage for yourself and family members who are currently uninsured or who are covered under another individual plan, or who are covered under a group health plan, group health benefits plan, a governmental plan, a church plan. Your application must be received during the designated Annual Open Enrollment Period. The Open Enrollment Period begins November 1, and continues until January 31 of the following year. Your application must be signed, dated and mailed during the Annual Open Enrollment Period. Coverage applied for by December 31 will be January 1 of the immediately following year & coverage applied for between January 1 and January 31 will be for February 1.
- F. A **Special Enrollment Period** that lasts for 60 days follows the Triggering Events. The effective date of a new policy will be no later than the first of the month following receipt of the application. In addition, if the Triggering Event is the loss of eligibility for minimum essential coverage, the Special Enrollment Period includes the 60 days prior to the Triggering Event.

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

Conditions of Enrollment – Applicant Acknowledgements and Agreements

On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer reporting agency, and any employer to give AmeriHealth New Jersey, or any consumer reporting agency acting on behalf of AmeriHealth New Jersey, information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that AmeriHealth New Jersey has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one.
4. I agree AmeriHealth New Jersey will provide coverage in accordance with the terms of the contract for the individual plan.
5. I understand that my enrollment and the enrollment of my listed dependents in AmeriHealth New Jersey's individual plan are subject to acceptance by AmeriHealth New Jersey.
6. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the individual plan if premiums are not paid timely.

Misrepresentations

Any person who includes any false or misleading information on a Nongroup Enrollment/Change Request Form for a health benefits plan is subject to criminal and civil penalties.