AmeriHealth PPO Group History Form (DE & NJ)							
IDENTIFYING INFORMA	ATION						
Customer Name:							
Customer Identification N	Number (CID):			_ Region Code:			
SOLD Effective Date:	//	Anniversary Date:	//				
GROUP STATUS					-		
Local [National	Broker	□ Active	Retiree	Association		
GROUP INFORMATION		•		•	•		
Lead Group #	New Group	p #	Existing Group #	Affil #			
Group Name (if other that	an customer name):				_		
Group Address:							
City, State, Zip:							
Group Leader:			Telephone: () _				
Union/Fund Name:		Unior	n/Fund Code:	Negotiation Date	e://		
Rating Contact (if other t	han group leader):			SIC #			
Number of Eligible Emplo				umber to be Enrolled:			
Number in AmeriHealth F	POS/HMO:						
BILLING INFORMATION							
Group Billing: D Month	ly (standard) Other	•	List Billing: 🗆	Quarterly (standard)	Monthly		
City, State, Zip:							
Billing Sort: D Alphal		Payroll Location (stated)	Indard National)	Other:			
REASON FOR GROUP			1	1			
□ New Business □			New Group	Additional LOB	Renewal		
Transfers	subscribers from existi	ng group #	_ to new group #				
Cancel existing group	(s)	OR 🗆 E	xisting group(s) to remain	in active			
Include new group # in e	xisting affiliation #	🛛 Yes	□ No □ Not a	applicable			
Change Affiliation #: D Y	′es □ No I	If yes, what is new affilia	tion #				
Transfer group from e	xisting affiliation	to new affiliation a	#				
New affiliation, affiliate	e with group(s):						
Other:							
Change group status:	Credible Inor	n-credible 🛛 🖵 U	pdate group benefits (co	omplete group history re	quired)		
Add to, or correct prev							
□ Other:	0 1 9						
Claims Fiduciary (Self-	Funded Groups Only	V)					
AmeriHealth is Claim	s Fiduciary-Medical/A	Ancillary (self-funded on	ly) Eff Date:/	/			
AmeriHealth is Claim			Eff Date:/				
AmeriHealth is Claim			Eff Date:/				
Group is Claims Fiduciary (self-funded only) Eff Date://							
EMPLOYER PARTICIPA							
Rate Notification:	60 days (standard)	d)	· · · · · · · · · · · · · · · · · · ·				
Participation:	None	□ 100% □ P	artial: % OF	R \$ Amount:	_		
	Other:		· · · · · · · · · · · · · · · · · · ·				
Pre-Existing Waiver:	Full waiver (stand	dard) 🛛 🗆 Initial E	Enrollees Only	No waiver			
DEPENDENT INFORMA			16				
Dependent Removal:	□ 1 st of Month Follow	ving Date of Ineligibility*	\Box 15 th of Month Follow	ing Date of Ineligibility*			
*date of ineligibility is dat NJ Only:	January (end of ca		□ Anniversary □	Other:			
Dependent Eligibility:		-					
Dependent Eligibility:							
Removal Method: Uverification (standard) Certification How Often?							
Prior Carrier Name: Code:							
RATING STATUS							
Fully Insured: D Comm	unity based, age, sex	(51-99) 🛛 Prospe	ective D Retrospec	tive			
Cost-Plus:	ate Basis 🛛 🖵 Cla	aims Reimbursement Ba	sis				
Stop Loss: Q	es 🗆 🗅 No	Specific	\$(\$7	75,000 is the standard)			
□ Aggregate% (125% is the standard)							
Tier Structure: 🛛 5 Tier	4 Tier (stand		2 Tier Composite	e			
RATING - SPECIAL FIN		MENTS					
90% Contingency	🖵 60-Day Delay	yed	Premium				
Other (explain):							

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□ 50%/50% □ \$15/\$35/\$50 □ \$10(\$20)\$50 □ \$200(20%\$2,000 □ \$2/\$6 □ \$10(\$20)\$50 □ 200(\$15/\$25/\$35) ○ 52/\$6 □ \$20(\$40)\$60 □ \$10(\$30)\$50 □ \$15/\$35/\$50 □ \$5/\$15/50% □ \$5/\$15/50% □ \$5/\$15/50% □ \$5/\$15/50% □ \$00(\$15/\$25/\$35) □ \$00(\$15/\$25/\$35) □ \$5/\$15/50% □ \$5/\$15/50% □ \$5/\$15/50% □ \$5/\$15/50% □ \$00(\$100 mist whichever is greater/1 Copay or Coinsurance [\$5/\$15/50% □ 90 day or 100 units whichever is greater/1 Copay or Coinsurance [\$10(\$20)\$50 □ 90 day or 100 units whichever is greater/1 Copay or Coinsurance [\$10(\$20)\$50 □ 90 day or 100 units whichever is greater/1 Copay or Coinsurance [\$10(\$20)\$50% □ 90 day or 100 units whichever is greater/1 Copay or Coinsurance [\$10(\$20)\$50% □ 90 day or 100 units whichever is greater/1 Copay or Coinsurance [\$10(\$20)\$50% □ 90 day or 100 units whichever is greater/1 Copay or Coinsurance [\$10(\$20)\$50% □ 90 day or 100 units whichever is greater/1 Copay or Coinsurance [\$10(\$20)\$50% □ 90 day or 100 units whichever is greater/1 Copay or Coinsurance [\$10(\$20)\$50% □ 90 day or 100 units whichever is greater/1 Copay or Coinsurance [\$10(\$20)\$50% □ 90 day or 100 units whichever is greater/1 Copay or Coinsurance [\$10(\$20)\$50% □ 90 day or 100 units whichever is greater/1 Copay or Coinsurance [\$10(\$20)\$50% □ 90 day or 100 units whichever is greater/1 Copay or Coinsurance [()		□ \$10/\$20/\$35				
(100+) \$20\$40/\$60 \$10\$30/\$50 \$150/30%\$3,000 \$4\\$8 \$5\$\$10/50% \$2756 \$156\$35,850 \$20\$40/\$60 \$156\$35,850 \$5\$\$20/50% \$5\$\$20/50% \$4\\$8 \$20\$40/\$60 \$5\$\$10/50% \$90 Day/3 Copays or Coinsurance \$5\$\$20/50% \$90 Day/3 Copays or Coinsurance \$5\$\$10/50% \$90 Day/3 Copays or Coinsurance (For Deductible/Copay Program, Deductible must be met first) \$5\$\$20/50% \$90 day or 100 units whichever is greater/1 Copay or Coinsurance (Standard Drug Only) Other (Rx Benefit Exception required):		□ \$10/\$30/\$50	\$5/\$20/\$50	\$100/20%/\$2,000			□ \$5/\$20/\$50	100/\$15/\$25/\$35		
\$2/\$6 \$15/\$35/\$50 \$5/\$15/50% \$4/\$8 \$20/\$40/\$60 \$90 Day/3 Copays or Coinsurance \$5/\$1050% 90 Day/3 Copays or Coinsurance \$5/\$10/50% \$5/\$1050% 90 day or 100 units whichever is greater/1 Copay or Coinsurance (Standard Drug Only) Other (Rx Benefit Exception required): 90 day or 100 units whichever is greater/1 Copay or Coinsurance (Standard Drug Only) Other (Rx Benefit Exception required): Exclude Contraceptives Other (Rx Benefit Exception required): Exclude Contraceptives Other (Rx Benefit Exception required): Exclude Contraceptives Other (Rx Benefit Exception required): Communits whichever is greater/1 Copay or Coinsurance (Standard Drug Only) Producing Agent Name:	□ 50%/50%	\$15/\$35/\$50	\$10/\$20/\$50	□ \$200/20%/\$2,000	□ \$2/\$6		\$10/\$20/\$50	200/\$15/\$25/\$35		
\$4/\$8 \$20/\$40/\$60 Drug Retail Dispensing \$5/\$20/50% \$5/\$10/50% 9 0 Day/3 Copays or Coinsurance \$5/\$20/50% \$5/\$10/50% 9 0 day or 100 units whichever is greater/1 Copay or Coinsurance (Standard Drug Only) Other (Rx Benefit Exception required): Exclude Contraceptives Other (Rx Benefit Exception required): Exclude Contraceptives Broker Consultant Broker of Record Letter on file: Yes No All AmeriHealth? Yes No Producing Agent Name:	(100+)	\$20/\$40/\$60	\$10/\$30/\$50	\$150/30%/\$3,000	□ \$4/\$8		\$5/\$10/50%			
\$4/\$8 \$20/\$40/\$60 Drug Retail Dispensing \$5/\$20/50% \$5/\$10/50% 9 0 Day/3 Copays or Coinsurance \$5/\$20/50% \$5/\$10/50% 9 0 day or 100 units whichever is greater/1 Copay or Coinsurance (Standard Drug Only) Other (Rx Benefit Exception required): Exclude Contraceptives Other (Rx Benefit Exception required): Exclude Contraceptives Broker Consultant Broker of Record Letter on file: Yes No All AmeriHealth? Yes No Producing Agent Name:	□ \$2/\$6		\$15/\$35/\$50				\$5/\$15/50%			
 \$\$5\\$10\50% \$\$5\\$15\50% \$\$5\\$15\50% \$\$5\\$15\50% \$\$5\\$20\50% \$\$5\\$20\50% \$\$5\\$20\50% \$\$5\\$20\50% \$\$0 day or 100 units whichever is greater/1 Copay or Coinsurance (Standard Drug Only) 0 Other (Rx Benefit Exception required): BROKER AND CONSULTANT INFORMATION			\$20/\$40/\$60		Drug Retail Dispe	ensina	\$5/\$20/50%			
St/\$15/50% St/\$20/50%	- • • • • •									
Style Style </td <td></td> <td></td> <td></td> <td></td> <td colspan="4"></td>										
 Exclude Contraceptives Other (Rx Benefit Exception required): Other (Rx Benefit Exception required): Other (Rx Benefit Exception required): Exclude Contraceptives Other (Rx Benefit Exception required): Broker AND CONSULTANT INFORMATION Broker Consultant Broker of Record Letter on file: Yes Yes No All AmeriHealth? Yes No All AmeriHealth? Yes No Yes No										
Other (Rx Benefit Exception required):										
					□ Other:					
 Other (Rx Benefit Exception required):		it Exception required).								
BROKER AND CONSULTANT INFORMATION Broker Consultant Broker of Record Letter on file: Yes No All AmeriHealth? Producing Agent Name: Producing Agency Name: Primary Broker Name: Firm Name: City, State, Zip: COMMISSION First Year: % Effective Date: // Renewal: @ Yes No If No, to follow by: // List of Subscribers Attached: @ Yes If Yes, Initial Ongoing					Exclude Contract	ceptives				
Broker Consultant Broker of Record Letter on file: Yes No All AmeriHealth? Yes No Producing Agent Name:					Other (Rx Bene Other)	fit Exception required):				
Broker Consultant Broker of Record Letter on file: Yes No All AmeriHealth? Yes No Producing Agent Name:	BROKER AND	CONSULTANT INI	FORMATION							
Producing Agency Name:										
Primary Broker Name:	Producing Agent Name: Telephone: ()									
Firm Name:	Producing Agency Name:									
City, State, Zip: COMMISSION First Year: % Effective Date: / / Renewal: % ENROLLMENT APPLICATIONS Applications Attached: Yes No Ist of Subscribers Attached: Yes No Tape Enrollment: No Yes, Initial	Primary Broker Name:									
COMMISSION First Year: % Effective Date: // Renewal: % ENROLLMENT APPLICATIONS Applications Attached: Yes No Ist of Subscribers Attached: Yes No Tape Enrollment: No Yes Initial	Firm Name:						·····			
First Year: % Effective Date: / / Renewal: % ENROLLMENT APPLICATIONS Applications Attached: Yes No If No, to follow by: ////////////////////////////////////	City, State, Zip:	<u></u>								
ENROLLMENT APPLICATIONS Applications Attached: Yes Ist of Subscribers Attached: Yes No If No, to follow by: //	COMMISSION									
Applications Attached: Yes No If No, to follow by: //_/	First Year:	%	Effective Date:	_// F	Renewal:	%				
List of Subscribers Attached: Yes No Tape Enrollment: Yes Yes Yes Yes, Initial Ongoing	ENROLLMENT	APPLICATIONS								
Tape Enrollment: INO Yes If Yes, Initial Ongoing				If No, to follow by: _	//					

MEDICARE SUPPLEMENT (DELAWARE ONLY) EFFECTIVE DATE:	<u> </u>					
🖵 Plan A 🔲 Plan B 🔲 Plan C 🔲 Plan E 🔲 Plan F 🗔 I	Plan I					
PROTECTION STARTS/ENDS						
Protection Starts: Date of HireD 30 Days D 60 Days D 90 Days						
Other (explain):						
Protection Ends (explain):						
Eligibility (1 st or 15 th of Month After) Date of Hire 30 Days 60 Da	ays 🔲 90 Days					
Other (explain):						
IDENTIFICATION CARDS						
ID Card Number: Social Security Number (standard) Certificate	Number 🛛 Other					
Mail ID Cards To: General Member (standard) Group or Figure 4 Gro						
Sort: Alphabetically (standard) Payroll Loc						
	I Others) Double (2 Cards for Single Contract, 4 Cards for All Others)					
Special ID Card Message: INO Yes If Yes, attach IC Request F BOOKLETS	orm and provide mock-up of front of ID card.					
Booklet included in Welcome Kit: Yes (standard) No						
Booklet Logo: INO Yes Custom Booklet: Custom Booklet Cover Name (<i>if applicable</i>):	□ No □ Yes					
Draft Required: INO Ves If Yes, Date Draft Required:						
Send Draft To (<i>if applicable</i>):						
WELCOME KITS						
Kits Required: 🛛 Yes (standard) 🗅 No Mail Kits To: 🗅 Memb	er (standard) Group or Fund Dother (specify):					
DELAWARE Total enrolled by option:	NEW JERSEY Total enrolled by option:					
Standard Value Series High Deductible Series	Standard Value Series High Deductible Series					
	5 5/15/70% 520/80%/50%: 10 10/20/70% 1020/80%/50%					
15 15/25/70% 2020/80%/50% 1	15 15/25/70% 2020/80%/50%					
310 20/30/70% 2520/80%/50% 250%/50%/50%/50%/50%/50%/50%/50%/50%/50%/	20 20/30/70% 2520/80%/50%					
	310 320					
	Group Specific					
PPO Group-Specific:	PPO Group-Specific:					
Flex Programs (available 4-1-2004)						
C1F101 C1F102 C1F201 C1F202						
C1F3O1 C1F3O2 C1F4O1 C1F4O2						
C2F101. C2F102 . C2F201. C2F202 . C2F301. C2F302 . C2F401. C2F402 .						
C2F3O1. C2F3O2 . C2F4O1. C2F4O2 . C3F1O1. C3F1O2 . C3F2O1. C3F2O2 .						
C3F3O1 C3F3O2 C3F4O1 C3F4O2						
FREESTANDING DRUG – DELAWARE/NEW JERSEY AFFIL #	EFFECTIVE DATE:					
Employee Only Employee & Dependents	Standard Drug 51+ Select Drug 51+ Deductible/Coinsurance (DE) \$\overlime{1}\\$3 (NJ Only) (NJ/DE) \$\overlime{1}\\$100/20%/\$2,000					
Dependent Children To Age:	□ \$2/\$6 (NJ Only) □ \$5/\$10/\$25 □ \$150/20%/\$2,000					
Dependent Students To Age:	□ \$2/\$10					
Include (check only those that apply for the programs below)	□ \$4/\$8 (NJ Only) □ \$5/\$10/\$50 □ \$250/20%/\$2,000					
	\$5/\$10 \$5/\$15/\$25 \$150/30%/\$3,000 \$5/\$15 \$5/\$15/\$35 \$200/30%/\$3,000					
Drug Retail Dispensing (NJ)	□ \$5/\$20 □ \$5/\$15/\$50					
90 Day/3 Copays or Coinsurance						
(For Deductible/Copay Program, Deductible must be met first) 90 Day/1 Copay (Standard Drug Only)	□ \$\$/\$14 (NJ Only) □ \$\$/\$20/\$50 □ \$10/\$15 (DE Only) □ \$10/\$20/\$35 Deductible/Copayment					
Other: (Rx Benefit Exception required)	$\Box $10/$20$ $\Box $10/$20/50 (NJ)					
	□ 80%/20% (DE Only) □ \$10/\$30/\$50 (DE Only) □ \$100/\$15/\$15					
	□ 50%/50% □ \$15/\$35/\$50 (DE Only) □ \$100/\$15/\$25 □ \$20/\$40/\$60 (DE Only) □ \$200/\$15/\$15					
	□ \$5/\$10/50% □ \$200/\$15/\$25/\$35					
VISION-ADMINISTERED BY DAVIS VISION AFFIL # EFFECTIVE DATE						
Employee Only	Frames/Lenses Code					
Employee & Dependents Dependent Children Covered To Age:	□ \$35					
Dependent Children Covered To Age: Dependent Students Covered To Age:	□ \$200					
- Dependent ofdachte overed to Age.	□ \$250					
	□ 1 Every Calendar Year					
	1 Every 2 Calendar Years					

LOCATION NAME ______ PAYROLL LOCATION #_____

RATES

ALL RATES QUOTED FOR _____

THROUGH

	Single	EE/Child	EE/Children	Two Person	Family	Total Composite
РРО						
Option						
Rating Type:						
Community/age/sex (51-99)						
Prospective						
Retrospective						
PPO <i>Flex Program</i> Option (DE only) C F O						
Rating Type: Community/age/sex (51-99)						
PPO RX						
Standard Drug						
Select Drug						
Ded/Coin (DE)						
Ded/Copay (NJ)						
Rating Type:						
Community, age, sex (51-99)						
Prospective						
□ Retrospective						
FREESTANDING RX						
Standard Drug						
Select Drug						
Ded/Coin (DE)						
Ded/Copay (NJ) Drug Retail Dispensing (NJ)						
90 Day/3 Copays or Coinsurance						
90 Day/1 Copay or Coinsurance (Standard Drug						
Only)						
□ Other:						
Rating Type: Community, age, sex (51-99)						
□ Prospective						
DAVIS VISION						
□ \$35						
\$100						
□ \$200						
□ \$250						
1every calendar year						
1 every 2 calendar years						
Rating Type:						
Community, age, sex (51-99)						
Plan B						
Plan E						
Plan F						
CARVEOUT Rating Type:						
······································						
Sales Representative:	Code:	:	Date:			
Approved by Sales Manager:			Date:			