AmeriHealth New Jersey
Application for Individual Coverage

APPLY

AmeriHealth New Jersey
259 Prospect Plains Rd, Building M
Cranbury, NJ 08512

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 Spouse	/ /	
	☐ Remove Civil Union Partner	/ /	
	☐ Remove Domestic Partner	/ /	
	☐ Remove Dependent Child	/ /	
OTHER CHANGES	☐ Name Change	/ /	
	☐ Change Plan	/ /	
	☐ Special Enrollment Period (following a Triggering Event*)	/ /	
	☐ Other	/ /	
	☐ Add/Change Office ID Numbers: Primary/OB/Gyn/Dentist	/ /	
	** See list of Triggering Events in Instructions*		

B. Applicant Information

Name (Last, First, MI):		SSN:	Birthdate (mm/dd/yyyy)
☐ Male ☐ Female	Are you a resident of New Jersey? ☐ Yes ☐ No	Do you maintain a home in any other state or country? ☐ Yes ☐ No If yes: 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: ☐ Primary residence ☐ Other residence ☐ P.O. Box or Other *(specify):*		
Activity	☐ Add ☐ Remove ☐ Other Change ☐ Continue *If a name change, indicate prior name:*		
	Primary Loc #:_____ NPI or PCP ID #:_____ Address:_____		
	Ob/Gyn Loc #:_____ NPI or PCP ID #:_____ Address:_____		
	Dentist Loc #:_____ NPI or PCP ID #:_____ Address:_____		
Are you eligible for Medicare? ☐ Yes ☐ No		Are you covered under any health coverage? ☐ Yes ☐ No If yes, why are you applying for individual coverage?_____	

C. Insert Plan Options:
☐ Medical Plan Name:
☐ Family Dental – Required (See instruction page for details)
☐ Adult Vision 100 ☐ Adult Vision 150 ☐ Adult Vision 180

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 if necessary.*

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) L: F: MI:	Name (last, first, MI) L: F: MI:	Name (last, first, MI) L: F: MI:	Name (last, first, MI) L: F: 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
Social Security Number:	Social Security Number:	Social Security Number:	Social Security Number:
Eligible for Medicare? ☐ Yes ☐ No Covered under any health coverage? ☐ Yes ☐ No	Eligible for Medicare? ☐ Yes ☐ No Covered under any health coverage? ☐ Yes ☐ No	Eligible for Medicare? ☐ Yes ☐ No Covered under any health coverage? ☐ Yes ☐ No	Eligible for Medicare? ☐ Yes ☐ No Covered under any health coverage? ☐ Yes ☐ No
Primary Care Provider: NPI or PCP ID #: Address:	Primary Care Provider: NPI or PCP ID #: Address:	Primary Care Provider: NPI or PCP ID #: Address:	Primary Care Provider: NPI or PCP ID #: Address:
Ob/Gyn Office: NPI or PCP ID #: Address:	Ob/Gyn Office: NPI or PCP ID #: Address:	Ob/Gyn Office: NPI or PCP ID #: Address:	Ob/Gyn Office: NPI or PCP ID #: Address:
Dentist Office: NPI or PCP ID #: Address:	Dentist Office: NPI or PCP ID #: Address:	Dentist Office: NPI or PCP ID #: Address:	Dentist Office: NPI or PCP ID #: Address:
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*

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

a. Street/Apt: Street/Apt: City, State, Zip Code:	b. Please explain why the address is different:

F. Additional Child Information – *Provide information below about children listed in Section D, if they have a different address. If multiple children reside 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:_____

Name(s):_____
Street/Apt:_____
Street/Apt:_____
City, State, Zip Code:_____

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.*

☐ Monthly ☐ Check ☐ Money Order

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: ____/____/____	NJ Producer License #
General Agent:		Agent ID #

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.
- 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. You should confirm the correct NPI number 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! A copy of this application may be used as a temporary ID card for 30 days from the effective date if authorized by. Coverage must be verified prior to visiting with a specialist or you may also register on amerihealthexpress.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. New dependent due to marriage, birth, adoption or placement for adoption, or placement in foster care.
  5. Gained access to New Jersey plans as a result of permanent move to New Jersey.
  6. In 2014 only, non-renewal of current individual coverage; enrollment may be requested within the 30 days prior to the non-renewal of the current coverage. Check the "Other Change" section in A.

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 eligible for Medicare.

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 Certificate of Exemption from the Marketplace. Attach a copy to your application.

E. The **Annual Open Enrollment Period** runs from October 15 through December 7 each year. Your application must be received during this time period. During the Annual Open Enrollment Period 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, or a church plan. The effective date of coverage will be January 1 of the calendar year following the Annual Open Enrollment Period.

F. The **Initial Enrollment Period** runs from October 1, 2013 through March 31, 2014. Your application must be received during this time period. During the Initial Enrollment Period you may apply for 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, or a church plan. The effective date of coverage will be January 1, 2014 or January 15, 2014 if the application is received by December 31, 2013 and for applications received after December 31st will be the first of the month following receipt of the application.

G. A **Special Enrollment Period** that lasts for 60 days follows the Triggering Events listed above. The effective date of a new policy will be no later than the first of the month following receipt of the application.

H. 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.

IMPORTANT: The Patient Protection and Affordable Care Act (PPACA) requires that you have pediatric dental coverage. To help you meet that requirement we have pre-selected our Smile for Health Family C40A50 dental plan which provides coverage for you and any eligible family members including pediatric dental coverage as required by PPACA. If you do not select the Smile for Health Family C40A50 dental plan, you will need to provide proof of coverage in another Pediatric Dental plan to ensure that you meet the Federal requirements under PPACA.