



Please mail to:
 AmeriHealth Insurance Company of New Jersey
 AmeriHealth HMO, Inc.
 259 Prospect Plains Road, Building M, Cranbury, NJ 08512
 Tel 609-662-2400 | www.amerithealthnj.com

Individual Coverage Application

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	<input type="checkbox"/> Enrollment of a new Subscriber		
	<input type="checkbox"/> Add Spouse		
	<input type="checkbox"/> Add Civil Union Partner		
	<input type="checkbox"/> Add Domestic Partner		
	<input type="checkbox"/> Add Dependent Child		
Remove	<input type="checkbox"/> Remove Subscriber		
	<input type="checkbox"/> Remove Spouse		
	<input type="checkbox"/> Remove Civil Union Partner		
	<input type="checkbox"/> Remove Domestic Partner		
	<input type="checkbox"/> Remove Dependent Child		
Other Changes	<input type="checkbox"/> Name Change		
	<input type="checkbox"/> Change Plan		
	<input type="checkbox"/> Special Enrollment Period (due to a Triggering Event*)		
	<input type="checkbox"/> Other		
	<input type="checkbox"/> 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
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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*)
 Mailing address (for communications other than bills: Primary residence Other residence P.O. Box or Other (*specify*)

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	Address Zip +4 Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
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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

Silver Portfolio

<input type="checkbox"/>	SELECT EPO AmeriHealth Advantage \$25/\$50
<input type="checkbox"/>	SELECT EPO HSA AmeriHealth Hospital Advantage \$50/\$75
<input type="checkbox"/>	SELECT HMO Local Value \$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 HSA AmeriHealth Hospital Advantage \$50/\$75
<input type="checkbox"/>	EPO AmeriHealth Advantage \$25/\$50
<input type="checkbox"/>	EPO Regional Preferred \$30/\$70

Gold Portfolio

<input type="checkbox"/>	EPO Regional Preferred \$30/\$50/20% Coins
<input type="checkbox"/>	HMO Regional Preferred \$15/\$30

AmeriHealth New Jersey Ancillary Plans

Pediatric Dental Options

Required: IHC Pediatric Dental IHC Pediatric Dental with Adult Preventative 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 100 Adult Vision 150 Adult Vision 180

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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	

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.*

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
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J. Broker/General Agent Signature

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



Individual Health Coverage Payment Form 2015

Payment options

AmeriHealth New Jersey offers various options for paying your premium. You can choose to make your **first monthly payment** by credit/debit card, or you can do a one-time ACH withdraw from your bank account.

Credit/Debit card

Please note that we will only accept Visa or MasterCard for credit/debit card payments, and you may only pay with a credit/debit card for the first month's premium.

Prepaid option

We are accepting all prepaid American Express, Visa, Master Card and Discover debit cards for your first month's premium.

INITIAL PAYMENT

Cardholder name: _____

Credit card type: Visa MasterCard

Prepaid: American Express Discover

Credit card number: _____

Security code: _____ Expiration date: _____

This 3 digit number can be found on the back of your card.

Cardholder's billing address: _____

City, State, ZIP: _____

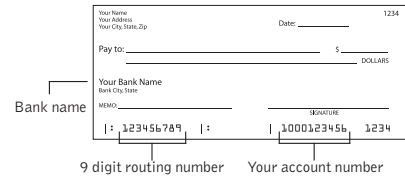
Individual Health Coverage Payment Form 2015

Automated payments through ACH

AmeriHealth New Jersey offers a free initial electronic one-time ACH withdraw. You authorize the withdrawal of your total premium amount due from your checking or savings account, and AmeriHealth New Jersey will deduct your payment through the ACH (Automated Clearing House) process.

Important instructions:

1. Complete and sign this form.
2. Attach a voided check (for checking accounts) or deposit slip (for savings accounts).
3. Return this form with your application.
4. **This form only collects your first monthly premium. To set up recurring monthly payments, log onto www.amerihealthexpress.com.**



Name on bank account:	
Bank routing/transfer number:	
Relationship to applicant:	
Bank account number:	
Name of financial institution:	
Type of account:	<input type="checkbox"/> Checking <input type="checkbox"/> Statement savings (No passbook accounts)
Bank account usage:	<input type="checkbox"/> Personal <input type="checkbox"/> Business

Account holder signature: _____ Date: _____

Additional signature (if joint account): _____ Date: _____

Signature of applicant: _____ Date: _____
(if different than account holder)

I (we) authorize my bank or savings institution to make payments to AmeriHealth New Jersey from the account listed above. I (we) understand this authorization may be revoked by me at any time, by written notification, to discontinue my automatic payment. I (we) agree to maintain sufficient funds in the account to permit these deductions. If the account does not maintain sufficient funds, electronic payments will be cancelled and I (we) will be billed through the postal service (regular mail).

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! A copy of this application may be used as a temporary ID card for 30 days from the effective date if authorized by AmeriHealth New Jersey. Coverage must be verified with AmeriHealth New Jersey prior to visiting with a specialist or admission to a hospital. 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. 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. 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).
 7. Child support order or other court order requiring coverage
 8. Application to NJ FamilyCare submitted during open enrollment period or during a special enrollment period is found ineligible.
 9. 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 December 15. Your application must be signed, dated and mailed during the Annual Open Enrollment Period. The effective date of coverage applied for by December 15, will be January 1, of the immediately following year.
- 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.