Group Enrollment/Change Request

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

AmeriHealth	Group Information — to be completed by Employer		
	Group Name	Group Number	Class Code

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

	Activity – Check all that apply	Effective Date/ Date of event	Date of Hire/Reason for Change
Add	Enrollment of a new Enrollee/Subscriber		
	Add Spouse		
	Add Civil Union Partner		
	Add Domestic Partner		
	Add Dependent Child		
	Add Over-Age Child as a Dependent Under 31*		
Remove	Employee Withdrawal/Termination		
	Remove Spouse		
	Remove Civil Union Partner		
	Remove Domestic Partner		
	Remove Dependent Child		
	Remove Over-Age Child as a Dependent Under 31		
Other Changes	Name change		
	Change plan		
	Other		
	Add/Change office ID numbers: Primary/OB/Gyn/Dentist		

Coverage Continuation		
	For Employee — Attach proof of disability	**Total Disability***
	COBRA/NJSGC Length of Continuation (in months): 18 29	
	Date of Loss of Coverage	Date of Qualifying Event
	Billing: Group Home (Section B)	Qualifying Event #†
	For Spouse/Civil Union Partner — Civil union partners are eligible to make an election pursuant to NJSGC, if applicable.	
	Length of Continuation (in months): 18 36	Date of Loss of Coverage
	Billing: Group Home (what address?) Section B OR Section F	Date of Qualifying Event
		Qualifying Event #†
	For Dependent/Over-age Child	**Dependent Under 31**
	COBRA/NJSGC Length of Continuation (in months): 18 36	
	Billing: Group‡ Home (what address?) Section B OR Section F	Date of Loss of Coverage
		Date of Qualifying Event
		Qualifying Event #†

B. Employee Information — To be completed by Employee.

Male Female	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.		

* Complete Coverage Continuation section
† Qualifying event #s: see list in Instructions.
‡ Billing through the group for a Dependent Under 31 Continuation Election requires agreement by the employer at Section J.

Group Enrollment/Change Request

B. Employee Information *(continued)*			
Address Information	**Home**		
	Street/Apt		
	Street/Apt	City	
	State	ZIP code	
	Work		
	Employer Name		
	Street/Apt	City	
	State	ZIP code	
	Email	Work Phone	
	Employment Date	Cell Phone	
	Hours worked per week		
	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	**Add** **Remove** **Other change** **Continue** *If a name change, indicate prior name:*		
	Primary Loc #	NPI or PCP ID #	
	Address	ZIP + 4	Current patient? Yes No
	Ob/Gyn Loc #	NPI #	
	Address	ZIP + 4	Current patient? Yes No
	Dentist Loc #	NPI #	
	Address	ZIP + 4	Current patient? Yes No
Other Health Coverage? Yes No	*If yes:*		
	Payer Name		
	Policy #		
	Medicare ID#, if any:		
Other Rx Coverage? Yes No	*If yes:*		
	Payer Name		
	Policy #		
	Medicare ID#, if any:		

C. Plan Options
Bronze Portfolio
Select EPO Local Value $40/$85
Select EPO Regional Preferred with NY $40/$85
Select EPO HSA AmeriHealth Hospital Advantage $50/$75
Select EPO HSA AmeriHealth Advantage LV $25/$50
Select EPO HSA AmeriHealth Advantage RP with NY $25/$50
Select EPO Local Value $50/$75
Select EPO Regional Preferred with NY $50/$75
Select EPO HSA Local Value 50%/50%
Select EPO HSA Regional Preferred with NY 50%/50%
EPO National Access with NY $50/$75
Select EPO HSA Local Value 0%/0%
Select EPO HSA Regional Preferred with NY 0%/0%

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C. Plan Options *(continued)*
Silver Portfolio
Select EPO Local Value $40/$75
Select EPO Regional Preferred with NY $40/$75
Select EPO AmeriHealth Hospital Advantage $50/$75
Select EPO HSA AmeriHealth Hospital Advantage $50/$75
Select EPO AmeriHealth Advantage LV $30/$60
Select EPO AmeriHealth Advantage RP with NY $30/$60
EPO National Access with NY $40/$75
Select EPO HSA Local Value 0%/0% $6,000
Select EPO HSA Regional Preferred with NY 0%/0% $6,000
Select EPO HSA Local Value 20%/20%
Select EPO HSA Regional Preferred with NY 20%/20%
Select EPO HSA Local Value 10%/10%
Select EPO HSA Regional Preferred with NY 10%/10%
Select EPO HSA Local Value 0%/0%
Select EPO HSA Regional Preferred with NY 0%/0%
EPO HSA National Access with NY 0%/0% $6,000
EPO HSA National Access with NY 0%/0%
Gold Portfolio
Select EPO AmeriHealth Advantage LV $20/$40
Select EPO AmeriHealth Advantage RP with NY $20/$40
Select EPO Local Value $30/$60
Select EPO Regional Preferred with NY $30/$60
Select EPO AmeriHealth Hospital Advantage $30/$50
EPO Local Value $35/$65
EPO Regional Preferred with NY $35/$65
EPO National Access with NY $35/$65
Select EPO Local Value $10/$40
Select EPO Regional Preferred with NY $10/$40
Select EPO HSA Local Value 0%/0%
Select EPO HSA Regional Preferred with NY 0%/0%
EPO National Access with NY $10/$40
EPO HSA National Access with NY 10%/10%
Platinum Portfolio
Select EPO Regional Preferred with NY $15/$30
EPO Regional Preferred with NY $10/$30
EPO National Access with NY $10/$30

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D. Other Individuals Covered — *Identify individuals for whom you are adding/changing/removing coverage. (Note: If the action applies to the Employee, include the information in Section B.) 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
Add Remove Other Continue Spouse Continue CU Partner (NJSGC)	Add Remove Other Continue	Add Remove Other Continue	Add Remove Other Continue
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)
Male Female	Male Female	Male Female	Male Female
SSN	SSN	SSN	SSN
Other Health Coverage Yes No	**Other Health Coverage** Yes No	**Other Health Coverage** Yes No	**Other Health Coverage** Yes No
If yes: Payer Name	***If yes:*** Payer Name	***If yes:*** Payer Name	***If yes:*** Payer Name
Policy #	Policy #	Policy #	Policy #
Current patient? Yes No	Current patient? Yes No	Current patient? Yes No	Current patient? Yes No
Other Rx Coverage Yes No	**Other Rx Coverage** Yes No	**Other Rx Coverage** Yes No	**Other Rx Coverage** Yes No
If yes: Payer Name	***If yes:*** Payer Name	***If yes:*** Payer Name	***If yes:*** Payer Name
Policy #	Policy #	Policy #	Policy #
Current patient? Yes No	Current patient? Yes No	Current patient? Yes No	Current patient? Yes No
Primary Care Provider NPI or PCP ID #	**Primary Care Provider** NPI or PCP ID #	**Primary Care Provider** NPI or PCP ID #	**Primary Care Provider** NPI or PCP ID #
Address	Address	Address	Address
ZIP+4	ZIP+4	ZIP+4	ZIP+4
Current patient? Yes No	Current patient? Yes No	Current patient? Yes No	Current patient? Yes No
OB/Gyn office NPI #	**OB/Gyn office** NPI #	**OB/Gyn office** NPI #	**OB/Gyn office** NPI #
Address	Address	Address	Address
ZIP+4	ZIP+4	ZIP+4	ZIP+4
Current patient? Yes No	Current patient? Yes No	Current patient? Yes No	Current patient? Yes No

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D. Other Individuals Covered *(continued)*			
1. Spouse/Domestic Partner/ Civil Union Partner	2. Child	3. Child	4. Child
Dentist office NPI #	**Dentist office** NPI #	**Dentist office** NPI #	**Dentist office** NPI #
Address	Address	Address	Address
ZIP+4	ZIP+4	ZIP+4	ZIP+4
Current patient? Yes No	Current patient? Yes No	Current patient? Yes No	Current patient? Yes No
Employed? Yes No *If YES, complete Section E1*	If last name is different from Employee, please explain	If last name is different from Employee, please explain	If last name is different from Employee, please explain
Home or billing address same as Employee? Yes No *If NO, complete Section E2*	Living with Employee? Yes No *If NO, complete Section F*	Living with Employee? Yes No *If NO, complete Section F*	Living with Employee? Yes No *If NO, complete Section F*

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

Name(s)		
Street/Apt		
Street/Apt	City	
State	ZIP code	Phone
Reason		

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G. Race/Ethnicity — The federal government is collecting information on race and ethnicity on covered persons. Enter a numbered code for race and ethnicity that best describes each person you are seeking to cover. You can choose up to three categories of race and two categories of ethnicity per person. Add additional pages if necessary for additional children. *Response is appreciated but NOT required!*
Choose a category that most closely describes you:

Race				**Ethnicity**	
1	White	11	Other Asian	1	Hispanic
2	Black or African American	12	Native Hawaiian or Other Pacific Islander	2	Not Hispanic
3	American Indian or Alaska Native	13	Native Hawaiian	3	Cuban
4	Asian	14	Guamanian or Chamorro	4	Mexican, Mexican American, Chicano/a
5	Asian Indian	15	Samoan	5	Puerto Rican
6	Chinese	16	Other Pacific Islander	6	An Ethnicity Not Listed Above
7	Filipino	17	Middle Eastern or North African	7	Unknown
8	Japanese	18	Another Race Not Listed Above	8	Decline to Respond
9	Korean	19	Unknown		
10	Vietnamese	20	Decline to Report		

Covered Person	Race Code	Race Code	Race Code	Ethnicity Code	Ethnicity Code
Applicant					
Spouse					
Child 1					
Child 2					
Child 3					

H. Employee'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.
I authorize deductions from my earnings for any contributions required from me.

Signature	Date

I. Over-Age Child's Signature

I represent that all the information supplied in this application regarding the Dependent Under 31 Continuation Election is true and complete.
I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form.
I hereby agree to make contributions required from me for the Dependent Under 31 Continuation Election.

Signature	Date

J. Employer Verification

The requested activity is believed eligible and is approved by the Employer.
In addition, the Employer consents to payroll deduction for Dependent Under 31 Continuation Election: Yes No

Employer Representative	Date
Representatives Title	

Conditions of Enrollment — *Employee acknowledgments 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, other medical care institution, carrier, consumer reporting agency, or employer to give AmeriHealth, or any consumer reporting agency acting on behalf of AmeriHealth, 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 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 will provide coverage in accordance with the terms of the contract for the individual plan.
5. 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 on time.

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Group Enrollment/Change Request

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.

Instructions

Employers – You must complete the [Employer] Group Information and sections A and J in order for this application to be processed.

Employees – You must complete sections B through H and submit the signature of each Over-Age Child for which a Dependent Under 31 Continuation Election is made in accordance with Section I in order for this application to be processed.

- Please PRINT except when a signature is requested.
- If a dependent is disabled and you want to continue his or her coverage beyond age 26, you do not have to make a COBRA/NJSGC or Dependent Under 31 election. Instead, select "Other" in Section A3, and attach proof of disability.
- For provider addresses, include the zip code plus the four digit extension (11 digits)
- You can obtain the providers' correct names and addresses from the appropriate provider directory. You may also obtain each provider's NPI number from the provider directory at: amerihealth.com/providerfinder 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.

Qualifying Events

COBRA and NJSGC

C1. Termination of job or reduction in hours
C2. Employee enrollment in Medicare (COBRA only)
C3. Divorce (COBRA/NJSGC); civil union dissolution (NJSGC)
C4. Death of employee
C5. Loss of dependent child status under the plan
C6. Disability (occurring subsequent to another qualifying event)

Dependent Under 31

D1. Loss of dependent status and otherwise eligible
D2. Reestablish eligibility: residency
D3. Reestablish eligibility: nonresident full-time student
D4. Reestablish eligibility: change in marital status
D5. Reestablish eligibility: change in parental status
D6. Reestablish eligibility: termination of other coverage

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