**Please Mail To:**
AmeriHealth Insurance Company of New Jersey
259 Prospect Plains Road, Building M,
Cranbury, NJ 08512

# AmeriHealth New Jersey SEH Group Application

Application for a small group employer health benefits policy

☐ New Policy ☐ Change in Policy ☐ Requested Effective Date:____/_____/_____

**Note**: The Effective Date will be on or after the date [Carrier] approves the application.

For AmeriHealth New Jersey use only
AmeriHealth Insurance Company of New Jersey | AmeriHealth HMO, Inc
Group Number:_______________________________________________

## Section I: Policy holder information

1. Policyholder (full legal name of Company):

2. Tax Identification Number:

3. Main Address
   Street:_______________________________________________
   City:_______________________________ State:______ Zip Code:______________
   Mailing Address
   Street:_______________________________________________
   City:_______________________________ State:______ Zip Code:______________
   Telephone: (______)_____________________________ Fax: (______)______________________
   Name of Group Administrator: ______________________ Email Address: ______________________

4. Type of Organization: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Other (explain)

5. Nature of business: (specify) | SIC Code:

6. Number of eligible employees in your company:_______________________________________
   **Please Refer to the New Jersey Small Employer Certification for the definition of an eligible employee.**

7. Number of eligible employees to be insured:

8. Class or classes to be excluded:

9. Insurance Requested For: ☐ Employees Only ☐ Employees and Dependents including Spouse ☐ Employees and Dependents excluding Spouse
   Should the plan provide coverage for domestic partners as permitted by P.L. 2003, c. 246? ☐ Yes ☐ No
   If yes, should the plan provide coverage for children of a covered domestic partner? ☐ Yes ☐ No

10. Are you subject to the requirements of COBRA? ☐ Yes ☐ No

11. Is the employer subject to the requirements of Medicare as Secondary Payor Rules for eligibility due to age? ☐ Yes ☐ No
    Is the employer subject to the requirements of Medicare as a Secondary Payor Rules for eligibility due to disability? ☐ Yes ☐ No

12. Orientation Period: ☐ Yes ☐ No

13. Waiting period before employees become insured (may not exceed 90 days):
    Present Employees:______________________________ New or Rehired Employees:______________________________

14. Period for Annual Employee Open Enrollment:

15. What percentage of the premium will the employer pay?

16. Deposit: $______________________________ Premium Paid: ☐ Monthly ☐ Automatic checking withdrawal
    **Premium will be due as of the effective date. The premium for the first month of coverage must be attached.**

17. Affiliates, subsidiaries or branches:
    **Must be included for purpose of participation**

| Legal Name & Location | Number of eligible employees in this company | Number of eligible employees to be insured |
|---|---|---|
| | | |
| | | |
| | | |

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**Section II:** Specifications for coverage

## Platinum Portfolio

| | AVAILABLE ON SHOP | OFF SHOP |
|---|---|---|
| ☐ | | EPO Local Value[11] – $15 / $30 |
| ☐ | | EPO Regional Preferred – $15 / $30 |
| ☐ | | EPO National Access – $15 / $30 |
| ☐ | | HMO Local Value[11] – $15 / $30 |
| ☐ | | HMO Regional Preferred – $15 / $30 |
| ☐ | | POS Plus Local Value[11] – $10 / $25 |
| ☐ | | POS Plus Regional Preferred – $10 / $25 |
| ☐ | ✔ | POS Plus National Access – $10 / $25 |
| ☐ | | POS Plus Local Value[11] – $15 / $30 |
| ☐ | | POS Plus Regional Preferred – $15 / $30 |
| ☐ | | POS Plus National Access – $15 / $30 |

## Gold Portfolio

| | AVAILABLE ON SHOP | OFF SHOP |
|---|---|---|
| ☐ | | EPO Local Value[12] – $30 / $50 |
| ☐ | ✔ | EPO Regional Preferred – $30 / $50 |
| ☐ | | EPO National Access – $30 / $50 |
| ☐ | | HMO Local Value[11] – $25 / $50, Rx 50% / $125 max |
| ☐ | | HMO Regional Preferred – $25 / $50, Rx 50% / $125 max |
| ☐ | | HMO Local Value[11] – $25 / $50, Rx 50% |
| ☐ | | HMO Regional Preferred – $25 / $50, Rx 50% |
| ☐ | | HMO Local Value[11] – $30 / $60 |
| ☐ | | HMO Regional Preferred – $30 / $60 |
| ☐ | | POS Local Value[11] – $30 / $60 |
| ☐ | | POS Regional Preferred – $30 / $60 |
| ☐ | | POS Plus Local Value[11] – $30 / $60 |
| ☐ | | POS Plus Regional Preferred – $30 / $60 |
| ☐ | | POS Plus National Access – $30 / $60 |
| ☐ | | HMO Plus Local Value[11] – $30 / $50 |
| ☐ | | HMO Plus Regional Preferred – $30 / $50 |
| ☐ | | HMO Plus Local Value[11] – $25 / $50 |
| ☐ | | HMO Plus Regional Preferred $25 / $50 |
| ☐ | ✔ | HMO Local Value[11] – $15 / $30 |
| ☐ | | HMO Regional Preferred – $15 / $30 |
| ☐ | | POS Plus Local Value[11] – $30 / $50 |
| ☐ | | POS Plus Regional Preferred – $30 / $50 |
| ☐ | ✔ | POS Plus National Access – $30 / $50 |
| ☐ | ✔ | EPO Community Advantage[7,12] – $10 / $20 |

## Silver Portfolio

| | AVAILABLE ON SHOP | OFF SHOP |
|---|---|---|
| ☐ | | POS Plus Local Value[11] – $50 / $75 |
| ☐ | | POS Plus Regional Preferred – $50 / $75 |
| ☐ | | POS Plus National Access – $50 / $75 |
| ☐ | ✔ | HMO Local Value[11] – $50 / $75 |
| ☐ | | HMO Regional Preferred – $50 / $75 |
| ☐ | ✔ | EPO HSA Tier 1 Advantage[10] – $15 / $35 |
| ☐ | ✔ | EPO Community Advantage[7,12] – $15 / $35 |
| ☐ | | EPO HSA Local Value[11] – 90% / 90% |
| ☐ | | EPO HSA Regional Preferred – 90% / 90% |
| ☐ | | EPO HSA National Access – 90% / 90% |
| ☐ | ✔ | EPO HSA Local Value[11] – 100% / 100% |
| ☐ | | EPO HSA Regional Preferred – 100% / 100% |
| ☐ | | EPO HSA National Access – 100% / 100% |

## Bronze Portfolio

| | AVAILABLE ON SHOP | OFF SHOP |
|---|---|---|
| ☐ | ✔ | EPO HSA Local Value[11] – 50% / 50% |
| ☐ | ✔ | EPO HSA Regional Preferred – 50% / 50% |
| ☐ | ✔ | EPO HSA National Access – 50% / 50% |
| ☐ | ✔ | EPO HSA Tier 1 Advantage[10] – $50 / $75 |
| ☐ | ✔ | EPO HSA Community Advantage[7,12] – $25 / $50 |

## AmeriHealth New Jersey SEH Ancillary Plans

### Adult Vision Options

| | |
|---|---|
| ☐ | $100 allowance |
| ☐ | $150 allowance |
| ☐ | $180 allowance |

### Pediatric Dental Options – Required

☐ Healthy Chompers Child ☐ Healthy Chompers Child with Adult Preventative ☐ Attest to having pediatric dental coverage elsewhere

In order to be compliant with the health care reform law, you must have Pediatric Dental coverage. To help you meet this requirement, AmeriHealth New Jersey is offering Pediatric Dental coverage through the Healthy Chompers Child, and Healthy Chompers Child with Adult Preventative Dental Plans underwritten by United Concordia. If you have already purchased group coverage that includes Pediatric Dental with another carrier, please let us know by providing a form of proof along with a signed attestation form. Doing so will help provide evidence of your dental coverage and compliance with federal regulations.

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## Section III: All questions must be answered

1. Is there any Group Health Plan now in force and to be continued? ☐ Yes ☐ No **If yes, identify:**
   a. Name of the Group Health Plan(s):____________________
   b. Description of the plan(s):____________________
   c. Name of insurance carrier(s):____________________

   Is there any Group Health Plan currently being applied for through another carrier? ☐ Yes ☐ No **If yes, identify:**
   a. Name of the Group Health Plan(s):____________________
   b. Description of the plan(s):____________________
   c. Name of insurance carrier(s):____________________

2. Name of present or prior group carrier: ____________________
   a. Effective date of prior coverage: ____/____/____
   b. Cancellation/Termination date: ____/____/____
   c. Is the coverage applied for in this application replacing other group insurance? ☐ Yes ☐ No
   d. If yes, explain reason: ____________________
   e. Plan being replaced: ____________________

3. Are extended benefits provided in case of termination of health benefits? ☐ Yes ☐ No
   If yes, explain reason: ____________________

4. To the best of your knowledge, are there any current or former employees or their eligible dependents whose health insurance is being continued? ☐ Yes ☐ No
   If yes, please provide the following information for each current/former employee or dependent on health continuations.

| Name of Employee/Dependent | Date of Birth | Type of Continuation State/ | Reason for Termination | Continuation Dates | |
|---|---|---|---|---|---|
| | | | | Start | End |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**If additional space is needed, please attach a separate sheet, signed and dated.**

5. To the best of your knowledge are any employees or dependents presently incapacitated? ☐ Yes ☐ No
   To the best of your knowledge are any dependent children incapable of self-support due to a physical or mental disability? ☐ Yes ☐ No

6. Does the employer participate in an arrangement with a Professional Employer Organization? ☐ Yes ☐ No
   **Refer to Advisory Bulletin 00-SEH-02 if you need information concerning what constitutes a Professional Employer Organization.**

## Section IV: Agent / Producer Information

Agent/Broker Name:

## Section V: Signature

It is understood that, except as provided under applicable regulations, no individual shall become insured while not actively at work on a full-time basis, and only full-time employees are eligible. A full-time employee is one who regularly works at least 25 hours per week at his employer's place of business. It is further understood that no agent has power on behalf of AmeriHealth HMO, Inc. and AmeriHealth Insurance Company of New Jersey to make or modify any request or application for insurance or to bind AmeriHealth HMO, Inc. and AmeriHealth Insurance Company of New Jersey by making any promise or representation or by giving or receiving any information.

It is further understood that no insurance will be effective unless and until the application is accepted in writing by AmeriHealth HMO, Inc. and/or AmeriHealth Insurance Company of New Jersey. Final rates will be based on enrollment data as of the policy effective date. No contract of insurance is to be implied in any way on the basis of the completion and/or submission of this application.

☐ Please read this statement and check to confirm. I confirm that I have received the Summary of Benefits and Coverage (SBC) documents associated with the plan or plans I selected on this application. I confirm I will provide SBCs to plan participants and beneficiaries as required by federal regulations and guidance related to the distribution of the SBC, including the requiring for timing and delivery.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

| Dated at: | Dated on: |
|---|---|
| Print name of Officer, Partner, or Proprietor: | Signature of Officer, Partner, or Proprietor: |
| Witness to Signature: | |

Note: If there are any modifications to the statement and answers given in this application (i.e. crossed out, whited-out, erased, etc.), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.

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