

# Application for Group Coverage

Thank you for applying for coverage from AmeriHealth HMO, Inc.  
Follow the instructions below to complete your application.

1. Carefully review and complete each section by printing clearly in black ink.
2. Your Group Administrator must complete section 2 before your application can be processed. If this is an application for a new member or a member changing plans, the Group Administrator must indicate the type of coverage elected.

HMO	POS	RX	Vision	Dental
_____	_____	_____	_____	_____

3. Provide information about your spouse and dependents only if they are also applying for coverage (Section 4). If you need additional space, attach a separate sheet with your signature and date. Important: You must include a Relationship Code (listed at the bottom of page 2) to indicate your relationship to each person covered under the plan.
4. Your Group Administrator must complete Section 7 and sign the application before it can be processed.
5. Before signing your application, please carefully read the Declarations and Conditions of Enrollment on page 4. Once you have completed and signed your application, be sure to make a copy for your records. Mail your application to or have your Group Administrator mail your paperwork to:

AmeriHealth  
P.O. Box 8240  
Philadelphia, PA 19101-8240

If you have any questions or need help completing this application, contact AmeriHealth at 1-800-275-2583, Monday through Friday, between 8 a.m. and 6 p.m. Brokers and small group employers should call 1-866-272-9684, Monday through Friday, 8:30 a.m. to 5 p.m., with any questions. Thank you for taking the time to complete your application. We look forward to having you as a member of the AmeriHealth family!



\*.RC09.\*



# Universal Enrollment Form

## SECTION 1 – Subscriber or member enrollment or change – Employee MUST complete in full

New <input type="checkbox"/> Open enrollment <input type="checkbox"/> Life event <input type="checkbox"/> New hire	Change <input type="checkbox"/> Address <input type="checkbox"/> Rehire <input type="checkbox"/> Last name <input type="checkbox"/> Dental office <input type="checkbox"/> Primary care office	Life event change <input type="checkbox"/> Marriage <input type="checkbox"/> Add a dependent <input type="checkbox"/> Delete a dependent <input type="checkbox"/> Other Life event date _____	Other change <input type="checkbox"/> COBRA Effective date _____ Effective Date of Coverage _____
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## SECTION 2: To be completed by Group Administrator

Plan (please specify copay or benefit option):  HMO                      POS _____                      _____  RX                      Vision                      Dental _____                      _____                      _____	Employment Status: <input type="checkbox"/> Active <input type="checkbox"/> Retiree	Terminate contract <input type="checkbox"/> Terminated employment <input type="checkbox"/> Full-time to part-time <input type="checkbox"/> Deceased. Indicate date. _____ <input type="checkbox"/> Other. Please Explain _____
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## SECTION 3: Subscriber information – please complete this entire section, whether you are a new applicant or are making a change to an existing contract

Social Security Number or ID number		Last name		Middle initial	First name
Gender M/F	Date of birth	Street address			Apt or suite
City		State	Zip code	Date of hire	
Telephone number including area code Home _____ Work _____		Coverage information <input type="checkbox"/> Employee and child <input type="checkbox"/> Employee and children <input type="checkbox"/> Employee only <input type="checkbox"/> Employee and spouse <input type="checkbox"/> Family		Primary Care Office ID number _____ Primary Dental office ID number _____	
				Primary Care Office name <input type="checkbox"/> Check if current patient Primary Dental Office name <input type="checkbox"/> Check if current patient	

## SECTION 4 – Family information (if applying)\*

Spouse name: Last, First, Middle Initial		Social Security Number			
Employer name	Birth date (mm/dd/yy) ____/____/____	Age	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Relationship Code:‡	
Primary care office/ PCP name (HMO/DPOS only)†		Primary Care Physician Office ID# (HMO ID#)†			
Current patient of PCP? (HMO/DPOS only)† <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary Dental Office ID#			

† A primary care physician (PCP) and primary dental office are required for all HMO/DPOS medical and dental plans. Use our website [www.amerhealth.com/findadoctor](http://www.amerhealth.com/findadoctor) to find a primary care physician (PCP) or a primary dental office. You can also call 215-241-CARE (2273) to request a PCP directory.

\* If you need to apply for additional dependents, please complete another application and mail it along with your primary application.

‡ Relationship Codes:

18 = Subscriber/Self (For dependents, value identifies relationship to the subscriber)  
 01 = Spouse  
 09 = Adopted Child  
 10 = Foster Child  
 17 = Stepson or Stepdaughter  
 19 = Child  
 31 = Court Appointed Guardian

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**SECTION 4 — Family information (continued)\***

Dependent <sup>††</sup> name: Last, First, Middle Initial		Social Security Number		
Relationship (e.g., son, stepdaughter)	Birth date (mm/dd/yy) ____/____/____	Age	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Relationship Code: <sup>‡</sup>
Primary care office/ PCP name (HMO/DPOS only) <sup>†</sup>	Primary Care Physician Office ID# (HMO ID#) <sup>†</sup>			
Current patient of PCP? (HMO/DPOS only) <sup>†</sup> <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary Dental Office ID#			

Dependent <sup>††</sup> name: Last, First, Middle Initial		Social Security Number		
Relationship (e.g., son, stepdaughter)	Birth date (mm/dd/yy) ____/____/____	Age	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Relationship Code: <sup>‡</sup>
Primary care office/ PCP name (HMO/DPOS only) <sup>†</sup>	Primary Care Physician Office ID# (HMO ID#) <sup>†</sup>			
Current patient of PCP? (HMO/DPOS only) <sup>†</sup> <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary Dental Office ID#			

Dependent <sup>††</sup> name: Last, First, Middle Initial		Social Security Number		
Relationship (e.g., son, stepdaughter)	Birth date (mm/dd/yy) ____/____/____	Age	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Relationship Code: <sup>‡</sup>
Primary care office/ PCP name (HMO/DPOS only) <sup>†</sup>	Primary Care Physician Office ID# (HMO ID#) <sup>†</sup>			
Current patient of PCP? (HMO/DPOS only) <sup>†</sup> <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary Dental Office ID#			

**SECTION 5: Dependent Information — If you listed dependents, you MUST answer these questions.**

Do any dependents listed live at another address? <input type="checkbox"/> Yes <input type="checkbox"/> No	If you answered yes to either question, please explain. _____ _____
Is any dependent's last name different from yours? <input type="checkbox"/> Yes <input type="checkbox"/> No	

† A primary care physician (PCP) and primary dental office are required for all HMO/DPOS medical and dental plans. Use our website [www.amerihealth.com/findadoctor](http://www.amerihealth.com/findadoctor) to find a primary care physician (PCP) or a primary dental office. You can also call 215-241-CARE (2273) to request a PCP directory.

†† Children under the age of 26 who meet eligibility requirements. Coverage can be applicable past age 26 if they are not self-supportive because of a mental or physical disability.

\* If you need to apply for additional dependents, please complete another application and mail it along with your primary application.

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## SECTION 6: Other insurance

Please list health insurance information if you or any dependents listed in Section 4 have other coverage.

Insurance Company Name	Policy Number	
_____	_____	
Policy Holder	Type of benefits	Effective date
_____	_____	_____

Are you or any of your dependents receiving Medicare Benefits?  Yes  No

Name	Medicare Number	Part A Effective Date	Part B Effective Date	Reason
Self	_____	_____	_____	Check all that apply <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD
Spouse	_____	_____	_____	
Child	_____	_____	_____	
Child	_____	_____	_____	

## SECTION 7: Group and employer information

Your Group Administrator MUST complete this section. Your application CANNOT be processed unless this section is complete.

Group name	Group number	Payroll/ Work Location
_____	_____	_____
Employer or Group Administrator signature	Date	Account number
_____	_____	_____

Your application cannot be processed without your signature.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I understand that the provision of services to me and my dependents as members of an AmeriHealth HMO or DPOS plan is governed by the applicable master group contract, which provides that:

- except for emergencies, all medical or dental care must be initiated at the primary care office or primary care dental office we have selected; and,
- I and my dependents authorize any person or organization provider services to furnish AmeriHealth HMO, Inc., its affiliates, and ancillary service providers who are responsible for administering certain covered services with medical or dental records or other information concerning such services for purposes including, but not limited to, AmeriHealth quality and utilization review.

I understand that if I chose a Direct Point of Service product (DPOS) I will be subject to applicable deductible, coinsurance, and other copayments for all self-referred services as specified in the contract.

I further understand that I can change health plans only at the time my employer and AmeriHealth specify.

Signature Required \_\_\_\_\_ Date \_\_\_\_\_  
 Subscriber's County of Residence \_\_\_\_\_

I acknowledge that I have read, understand all statements in this application, and have supplied the requested information. The information supplied on the application and any signed addendum is accurate and complete to the best of my knowledge. No material information has been withheld or omitted on any person applying. I understand that if my signature and date do not appear and/or my answers are incomplete, the application will either be rejected or returned for completion.

\*.RC09.\*

