



New business:

Fax to 215-238-2508 or 215-238-2507
Form must be sent with new business submission and tracking cover sheet.

Retention business:

AmeriHealth New Jersey Account Executive

AmeriHealth New Jersey SEH Group Application

Application for a small group health benefits policy

New Policy Change in Policy Requested Effective Date: ___ / ___ / ___

Note: The Effective Date will be on or after the date AmeriHealth New Jersey approves the application.

Please print or type

Policy Number: _____

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: () _____ Facsimile () _____ Email Address: _____		
Contract information should be provided <input type="checkbox"/> electronically or <input type="checkbox"/> hard copy. Check one. Correspondent: _____		
4. Type of Organization: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship <input type="checkbox"/> Other (explain) _____		
5. Nature of business: (specify)	SIC Code: _____	
6. Number of full-time employees in your company: _____ Please Refer to the New Jersey Small Employer Certification for the definition of a full-time employee.		
7. Number of full-time employees to be insured:		
8. Class or classes to be excluded:		
9. Insurance Requested For: <input type="checkbox"/> Employees Only <input type="checkbox"/> Employees and Dependents including Spouse <input type="checkbox"/> Employees and Dependents excluding Spouse Should the plan provide coverage for domestic partners as permitted by P.L. 2003, c. 246? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, should the plan provide coverage for coverage of children of a covered domestic partner? <input type="checkbox"/> Yes <input type="checkbox"/> No		
10. Is the employer subject to the requirements of COBRA? <input type="checkbox"/> Yes <input type="checkbox"/> No		
11. Is the employer subject to the requirements of Medicare as Secondary Payor Rules for eligibility due to age? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the employer subject to the requirements of Medicare as a Secondary Payor Rules for eligibility due to disability? <input type="checkbox"/> Yes <input type="checkbox"/> No		
12. Orientation Period: <input type="checkbox"/> Yes <input type="checkbox"/> No		
13. Waiting period before employees become insured (may not exceed 90 days): The <input type="checkbox"/> 1st or <input type="checkbox"/> 15th of the month following the waiting period of: <input type="checkbox"/> 0 days <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> exactly 90 days for: <input type="checkbox"/> Present Employees: _____ <input type="checkbox"/> New Employees: _____ <input type="checkbox"/> Rehired Employees: _____		
14. Period for Annual Employee Open Enrollment:		
15. What percentage of the premium will the employer pay?		
16. Deposit: \$ _____ Premium Paid: <input type="checkbox"/> Monthly <input type="checkbox"/> 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 full-time employees in this company	Number of full-time employees to be insured



Section II: Specifications for coverage

New business - Please choose from the plan options below.

Retention business - If renewing into new medical benefits, please choose from the plan options below.

Please check box if only selecting new dental benefits.

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

Bronze Portfolio

	AVAILABLE ON SHOP	
<input type="checkbox"/>	✓	EPO HSA Local Value \$50/\$75
<input type="checkbox"/>	✓	EPO HSA Regional Preferred \$50/\$75
<input type="checkbox"/>	✓	EPO HSA National Access \$50/\$75
<input type="checkbox"/>		EPO Local Value \$50/\$75
<input type="checkbox"/>		EPO Regional Preferred \$50/\$75
<input type="checkbox"/>		EPO National Access \$50/\$75
<input type="checkbox"/>	✓	EPO Tier 1 Advantage \$50/\$75
<input type="checkbox"/>	✓	EPO AmeriHealth Advantage \$25/\$50

Silver Portfolio

	AVAILABLE ON SHOP	
<input type="checkbox"/>		POS Plus Local Value \$50/\$75
<input type="checkbox"/>		POS Plus Regional Preferred \$50/\$75
<input type="checkbox"/>	✓	POS Plus National Access \$50/\$75
<input type="checkbox"/>	✓	HMO Local Value \$50/\$75
<input type="checkbox"/>		HMO Regional Preferred \$50/\$75
<input type="checkbox"/>	✓	EPO HSA Tier 1 Advantage \$50/\$75
<input type="checkbox"/>	✓	EPO AmeriHealth Advantage \$15/\$35
<input type="checkbox"/>		EPO Local Value \$30/\$50/80% Coins
<input type="checkbox"/>		EPO Regional Preferred \$30/\$50/80% Coins
<input type="checkbox"/>		EPO National Access \$30/\$50/80% Coins
<input type="checkbox"/>		EPO Local Value \$30/\$50/50% Coins
<input type="checkbox"/>	✓	EPO Regional Preferred \$30/\$50/50% Coins
<input type="checkbox"/>		EPO National Access \$30/\$50/50% Coins
<input type="checkbox"/>		EPO HSA Local Value \$30/\$50
<input type="checkbox"/>		EPO HSA Regional Preferred \$30/\$50
<input type="checkbox"/>		EPO HSA National Access \$30/\$50
<input type="checkbox"/>		EPO HSA Local Value 90%/90%
<input type="checkbox"/>	✓	EPO HSA Regional Preferred 90%/90%
<input type="checkbox"/>		EPO HSA National Access 90%/90%
<input type="checkbox"/>	✓	EPO HSA Local Value 100%/100%
<input type="checkbox"/>		EPO HSA Regional Preferred 100%/100%
<input type="checkbox"/>		EPO HSA National Access 100%/100%

Gold Portfolio

	AVAILABLE ON SHOP	
<input type="checkbox"/>		EPO Local Value \$30/\$50/80% Coins
<input type="checkbox"/>	✓	EPO Regional Preferred \$30/\$50/80% Coins
<input type="checkbox"/>		EPO National Access \$30/\$50/80% Coins
<input type="checkbox"/>		HMO Local Value \$25/\$50, Rx 50%/\$125 max
<input type="checkbox"/>		HMO Regional Preferred \$25/\$50, Rx 50%/\$125 max
<input type="checkbox"/>		HMO Local Value \$25/\$50, Rx 50%
<input type="checkbox"/>		HMO Regional Preferred \$25/\$50, Rx 50%
<input type="checkbox"/>		HMO Local Value \$30/\$60
<input type="checkbox"/>		HMO Regional Preferred \$30/\$60
<input type="checkbox"/>		POS Local Value \$30/\$60
<input type="checkbox"/>		POS Regional Preferred \$30/\$60
<input type="checkbox"/>		POS Plus Local Value \$30/\$60
<input type="checkbox"/>		POS Plus Regional Preferred \$30/\$60
<input type="checkbox"/>		POS Plus National Access \$30/\$60
<input type="checkbox"/>		HMO Plus Local Value \$30/\$50
<input type="checkbox"/>		HMO Plus Regional Preferred \$30/\$50
<input type="checkbox"/>		HMO Plus Local Value \$25/\$50
<input type="checkbox"/>		HMO Plus Regional Preferred \$25/\$50
<input type="checkbox"/>	✓	HMO Local Value \$15/\$30
<input type="checkbox"/>		HMO Regional Preferred \$15/\$30
<input type="checkbox"/>		POS Plus Local Value \$30/\$50
<input type="checkbox"/>		POS Plus Regional Preferred \$30/\$50
<input type="checkbox"/>	✓	POS Plus National Access \$30/\$50
<input type="checkbox"/>		POS Plus Local Value \$20/\$40
<input type="checkbox"/>	✓	POS Plus Regional Preferred \$20/\$40
<input type="checkbox"/>		POS Plus National Access \$20/\$40
<input type="checkbox"/>		POS Local Value \$30/\$50/70% Coins
<input type="checkbox"/>		POS Regional Preferred \$30/\$50/70% Coins
<input type="checkbox"/>		EPO HSA Local Value 100%/100%
<input type="checkbox"/>	✓	EPO HSA Regional Preferred 100%/100%
<input type="checkbox"/>		EPO HSA National Access 100%/100%
<input type="checkbox"/>		EPO HSA Local Value \$20/\$40
<input type="checkbox"/>		EPO HSA Regional Preferred \$20/\$40
<input type="checkbox"/>		EPO HSA National Access \$20/\$40
<input type="checkbox"/>		EPO HSA Local Value 70% Coins, RX \$10/\$40/\$60
<input type="checkbox"/>		EPO HSA Regional Preferred 70% Coins, RX \$10/\$40/\$60
<input type="checkbox"/>		EPO HSA National Access 70% Coins, RX \$10/\$40/\$60
<input type="checkbox"/>		EPO HSA Local Value 70% Coins, RX \$7/50%/\$125 max
<input type="checkbox"/>		EPO HSA Regional Preferred 70% Coins, RX \$7/50%/\$125 max
<input type="checkbox"/>		EPO HSA National Access 70% Coins, RX \$7/50%/\$125 max
<input type="checkbox"/>		EPO Local Value \$30/\$50/70% Coins
<input type="checkbox"/>		EPO Regional Preferred \$30/\$50/70% Coins
<input type="checkbox"/>		EPO National Access \$30/\$50/70% Coins
<input type="checkbox"/>	✓	EPO AmeriHealth Advantage \$10/\$20

Platinum Portfolio		
	AVAILABLE ON SHOP	
<input type="checkbox"/>		EPO Local Value \$15/\$30
<input type="checkbox"/>		EPO Regional Preferred \$15/\$30
<input type="checkbox"/>		EPO National Access \$15/\$30
<input type="checkbox"/>	✓	HMO Local Value \$15/\$30
<input type="checkbox"/>		HMO Regional Preferred \$15/\$30
<input type="checkbox"/>		POS Plus Local Value \$10/\$25
<input type="checkbox"/>		POS Plus Regional Preferred \$10/\$25
<input type="checkbox"/>	✓	POS Plus National Access \$10/\$25
<input type="checkbox"/>		POS Plus Local Value \$15/\$30
<input type="checkbox"/>		POS Plus Regional Preferred \$15/\$30
<input type="checkbox"/>		POS Plus National Access \$15/\$30
<input type="checkbox"/>		EPO Local Value \$20/\$40
<input type="checkbox"/>	✓	EPO Regional Preferred \$20/\$40
<input type="checkbox"/>	✓	EPO National Access \$20/\$40
<input type="checkbox"/>		POS Plus Local Value \$30/\$40
<input type="checkbox"/>	✓	POS Plus Regional Preferred \$30/\$40
<input type="checkbox"/>		POS Plus National Access \$30/\$40
<input type="checkbox"/>		POS Plus Local Value \$20/\$40
<input type="checkbox"/>		POS Plus Regional Preferred \$20/\$40
<input type="checkbox"/>		POS Plus National Access \$20/\$40
<input type="checkbox"/>		POS Plus Local Value \$20/\$40/90% Coins
<input type="checkbox"/>		POS Plus Regional Preferred \$20/\$40/90% Coins
<input type="checkbox"/>		POS Plus National Access \$20/\$40/90% Coins

AmeriHealth New Jersey SEH Ancillary Plans

Adult Vision Options

\$100 allowance \$150 allowance \$180 allowance

Pediatric Dental Options – Required

SEH Pediatric Dental SEH Pediatric Dental with Adult Preventive SEH Family Dental

The Patient Protection and Affordable Care Act (PPACA) allows for plans outside of the Small Business Health Options Program (SHOP) to issue coverage without pediatric dental benefits as long as the applicant provides reasonable assurance that an exchange-certified Stand-Alone Dental Plan (SADP) covering the pediatric dental benefits has been purchased elsewhere. To help you meet this requirement, AmeriHealth New Jersey is offering pediatric dental coverage through our SEH Pediatric Dental, SEH Pediatric Dental with Adult Preventive, and SEH Family Dental plans.

Attest to having pediatric dental coverage elsewhere

If you did not select one of the stand-alone pediatric dental plans listed above, we require one of the following options as proof of coverage in order to receive reasonable assurance from you.

- Option 1 – Please provide supporting documentation such as:
- Copy of dental policy document, which includes specific reference to coverage of pediatric dental benefit; OR
 - Welcome letter from dental carrier, which includes specific reference to coverage of pediatric dental benefit; OR
 - Current invoice from dental carrier, which includes specific reference to coverage of pediatric dental benefit;

For new and retention business, please submit supporting documentation to: AHNJdentalattestation@amerihealth.com or fax to 609-662-2630.

Option 2 – Please provide the contact information of your pediatric dental carrier for proof of coverage by completing the section below.

Dental Carrier Name:	Dental Product Name:
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Effective date for current Pediatric Dental coverage: ___ / ___ / ___	Group Dental Policy Number:
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Section III: All questions must be answered

Is there any Group Health Plan:

- now in force and to be continued? Yes No
- currently being applied for? Yes No

If "Yes" identify the name of the Group Health Plan, give a description of the plan(s) and 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

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/ Federal/Extended Benefits	Reason for Termination Disability/Other	Continuation Dates	
				Start	End

If additional space is needed, 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
Additional space to explain if Items 1, 2 or 3 were answered "Yes". Refer to the question number, and give details including names, where appropriate. _____

6. Does the employer participate in an arrangement with a Professional Employer Organization (PEO)? 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 (Refer to the definition on the New Jersey Employer Certification). 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.

It is understood that I am responsible to provide AmeriHealth HMO, Inc. and AmeriHealth Insurance Company of New Jersey with timely and accurate information regarding the date of hire for new employees and that the requested effective date of coverage will properly apply any orientation period and waiting period requirements applicable to my plan. It is further understood that any retroactive termination requests must be limited to those for which no premium or contribution has been paid for the termination period by the employee or dependent whose coverage is to be retroactively terminated.

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 statements and answers given in this application (i.e. crossed out, whited-out, erased, information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.