AmeriHealth

Nongroup Enrollment/Change Request

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

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

	Activity – Check all that apply	Date of event	Reason
Add	Enrollment of a new Subscriber		
	Add Spouse		
	Add Civil Union Partner		
	Add Domestic Partner		
	Add Dependent Child		
Remove	Remove Subscriber		
	Remove Spouse		
	Remove Civil Union Partner		
	Remove Domestic Partner		
	Remove Dependent Child		
Other Changes	Name change		
	Change plan		
	Special Enrollment Period (due to a Triggering Event*)		
	Other		
	Add/Change office ID numbers: Primary/OB/Gyn/Dentist		

B. Subscriber 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.

Sex assigned at birth	Are you a resident of New Jersey?	Do you maintain a home in any other state or country? Yes No
Male Female Other Prrefer not to share	Yes No	***If yes to the above***, name of state/country Number of months you live there each year

Address Information	**Primary Residence**	
	Street/Apt	
	Street/Apt	City
	State	ZIP code
	Other Residence	
	Street/Apt	
	Street/Apt	City
	State	ZIP code
	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*)	
Coverage Information	Are you, as the applicant, requesting to be covered under the policy for which you are completing this enrollment form? Yes No **If yes**, complete the Activity section on the next page and respond to the Medicare and health coverage questions before proceeding to the Medical Plan Options in Section C. If you are not requesting to be covered under the policy for which you are completing this enrollment form but you are requesting coverage for multiple children only, do not complete the Activity section and do not respond to the Medicare and health coverage questions. Proceed to the Medical Plan Options in Section C. Use Section D, Other Individuals Covered, to name the children for whom you are applying for coverage.	

* See list of Triggering Events in instructions. Provide evidence of Triggering Event with the enrollment form.

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B. Subscriber Information *(continued)*

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	

Are you covered under Medicare Parts A or B? Yes No	
Are you eligible under any health coverage? Yes No If yes, why are you applying for individual coverage?	

Subscriber Race/Ethnicity — *Response is appreciated but NOT required!*

Racial Identity			*(Select all that apply)*
	American Indian or Alaskan Native	Asian	Black or African American
	Native Hawaiian or Other Pacific Islander	White	Unknown
	Other	Prefer not to share	
Ethnic Identity	Hispanic/Latino	Non-Hispanic/Latino	Unknown
	Prefer not to share		
Preferred Language	English	Spanish	Chinese
	Italian	Portuguese	Other
	Prefer not to share		

Cultural Identity						*(Select up to 5)*
	Cherokee	Asian Indian	African	Guamanian or Chamorro	English	Colombian
	Nanticoke Lenni-Lenape	Chinese	Ghanian	Micronesian	German	Dominican (Dominican Republic)
	Navajo	Filipino	Haitian	Native Hawaiian	Irish	Ecuadorian
	Powhatan Renape Nation	Korean	Jamaican	Polynesian	Italian	Mexican
	Ramapough Lenape Indian Nation	Vietnamese	Nigerian	Samoan	Polish	Puerto Rican
	Other	Prefer not to share				

C. Medical Plan Options

Catastrophic portfolio	
Select plan	
☐	Local Value Simple Saver
Bronze portfolio	
☐	EPO HSA AmeriHealth Advantage $25/$50
☐	EPO HSA AmeriHealth Hospital Advantage $50/$75
☐	EPO HSA Local Value 50%/50%
☐	EPO Local Value $50/$75

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C. **Medical Plan Options** *(continued)*	
Silver portfolio	
☐	Select EPO AmeriHealth Advantage $25/$60
☐	Select EPO HSA AmeriHealth Hospital Advantage $50/$75
☐	EPO AmeriHealth Advantage $45/40%
	EPO AmeriHealth Advantage $25/$60
	EPO HSA AmeriHealth Hospital Advantage $50/$75
☐	EPO AmeriHealth Hospital Advantage $50/$75
☐	EPO HSA Local Value $50/$75
☐	EPO HSA Regional Preferred $50/$75
Gold portfolio	
☐	EPO Regional Preferred $30/$50
AmeriHealth Ancillary Plans	
Pediatric dental options Required:	
	IHC Pediatric Dental
	IHC Pediatric Dental with Adult Preventive
	IHC Family Plus Dental
	Attest to pediatric dental coverage elsewhere
IMPORTANT: The Patient Protection and Affordable Care Act (PPACA) requires that you have pediatric dental coverage for any eligible family members younger than 19. All of AmeriHealth's dental plan options satisfy this requirement.	
Adult vision options	
	Adult Vision Care $100/$150
	Adult Vision Care $130/$180
	Adult Vision Care $150/$200

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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 Subscriber, 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	Add Remove Other	Add Remove Other	Add Remove 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)
Sex assigned at birth Male Female Other Prefer not to share	Sex assigned at birth Male Female Other Prefer not to share	Sex assigned at birth Male Female Other Prefer not to share	Sex assigned at birth Male Female Other Prefer not to share
SSN	SSN	SSN	SSN
Eligible for Medicare? Yes No	Eligible for Medicare? Yes No	Eligible for Medicare? Yes No	Eligible for Medicare? Yes No
Covered under Medicare Parts A or B? Yes No	Covered under Medicare Parts A or B? Yes No	Covered under Medicare Parts A or B? Yes No	Covered under Medicare Parts A or B? Yes No
Covered under any health coverage? Yes No	Covered under any health coverage? Yes No	Covered under any health coverage? Yes No	Covered under any health coverage? 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
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
If last name is different from Subscriber, please explain	If last name is different from Subscriber, please explain	If last name is different from Subscriber, please explain	If last name is different from Subscriber, please explain
Home address same as Subscriber? Yes No *If NO, complete Section E*	Home address same as Subscriber? Yes No *If NO, complete Section F*	Home address same as Subscriber? Yes No *If NO, complete Section F*	Home address same as Subscriber? Yes No *If NO, complete Section F*

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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	

Spouse / Civil Union Partner / Domestic Partner Race/Ethnicity — *Response is appreciated but NOT required!*

Racial Identity			*(Select all that apply)*
	American Indian or Alaskan Native	Asian	Black or African American
	Native Hawaiian or Other Pacific Islander	White	Unknown
	Other	Prefer not to share	
Ethnic Identity	Hispanic/Latino	Non-Hispanic/Latino	Unknown
	Prefer not to share		
Preferred Language	English	Spanish	Chinese
	Italian	Portuguese	Other
	Prefer not to share		

Cultural Identity						*(Select up to 5)*
	Cherokee	Asian Indian	African	Guamanian or Chamorro	English	Colombian
	Nanticoke Lenni-Lenape	Chinese	Ghanian	Micronesian	German	Dominican (Dominican Republic)
	Navajo	Filipino	Haitian	Native Hawaiian	Irish	Ecuadorian
	Powhatan Renape Nation	Korean	Jamaican	Polynesian	Italian	Mexican
	Ramapough Lenape Indian Nation	Vietnamese	Nigerian	Samoan	Polish	Puerto Rican
	Other	Prefer not to share				

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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E. Additional Child Information *(continued)*

Child 1 Race/Ethnicity — *Response is appreciated but NOT required!*

Racial Identity						*(Select all that apply)*
	American Indian or Alaskan Native		Asian		Black or African American	
	Native Hawaiian or Other Pacific Islander		White		Unknown	
	Other		Prefer not to share			
Ethnic Identity	Hispanic/Latino		Non-Hispanic/Latino		Unknown	
	Prefer not to share					
Preferred Language	English		Spanish		Chinese	
	Italian		Portuguese		Other	
	Prefer not to share					
Cultural Identity						*(Select up to 5)*
	Cherokee	Asian Indian	African	Guamanian or Chamorro	English	Colombian
	Nanticoke Lenni-Lenape	Chinese	Ghanian	Micronesian	German	Dominican (Dominican Republic)
	Navajo	Filipino	Haitian	Native Hawaiian	Irish	Ecuadorian
	Powhatan Renape Nation	Korean	Jamaican	Polynesian	Italian	Mexican
	Ramapough Lenape Indian Nation	Vietnamese	Nigerian	Samoan	Polish	Puerto Rican
	Other	Prefer not to share				

Child 2 Race/Ethnicity — *Response is appreciated but NOT required!*

Racial Identity						*(Select all that apply)*
	American Indian or Alaskan Native		Asian		Black or African American	
	Native Hawaiian or Other Pacific Islander		White		Unknown	
	Other		Prefer not to share			
Ethnic Identity	Hispanic/Latino		Non-Hispanic/Latino		Unknown	
	Prefer not to share					
Preferred Language	English		Spanish		Chinese	
	Italian		Portuguese		Other	
	Prefer not to share					
Cultural Identity						*(Select up to 5)*
	Cherokee	Asian Indian	African	Guamanian or Chamorro	English	Colombian
	Nanticoke Lenni-Lenape	Chinese	Ghanian	Micronesian	German	Dominican (Dominican Republic)
	Navajo	Filipino	Haitian	Native Hawaiian	Irish	Ecuadorian
	Powhatan Renape Nation	Korean	Jamaican	Polynesian	Italian	Mexican
	Ramapough Lenape Indian Nation	Vietnamese	Nigerian	Samoan	Polish	Puerto Rican
	Other	Prefer not to share				

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E. Additional Child Information *(continued)*

Child 3 Race/Ethnicity — *Response is appreciated but NOT required!*

Racial Identity						*(Select all that apply)*
	American Indian or Alaskan Native		Asian		Black or African American	
	Native Hawaiian or Other Pacific Islander		White		Unknown	
	Other		Prefer not to share			
Ethnic Identity	Hispanic/Latino		Non-Hispanic/Latino		Unknown	
	Prefer not to share					
Preferred Language	English		Spanish		Chinese	
	Italian		Portuguese		Other	
	Prefer not to share					
Cultural Identity						*(Select up to 5)*
	Cherokee	Asian Indian	African	Guamanian or Chamorro	English	Colombian
	Nanticoke Lenni-Lenape	Chinese	Ghanian	Micronesian	German	Dominican (Dominican Republic)
	Navajo	Filipino	Haitian	Native Hawaiian	Irish	Ecuadorian
	Powhatan Renape Nation	Korean	Jamaican	Polynesian	Italian	Mexican
	Ramapough Lenape Indian Nation	Vietnamese	Nigerian	Samoan	Polish	Puerto Rican
	Other	Prefer not to share				

G. Payment Information — *Indicate how you would like to be billed and make payment.*

Check	Money order	Credit/Debit card (***first payment only***)	Pre-paid debit card	
Credit/Debit card type	American Express	Discover	MasterCard	Visa
Credit/Debit card #		Expiration date		Security code
Cardholder name				

H. Subscriber'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

I. Broker / General Agent Signature

Signature of Preparer	Date	NJ Producer License #
		NPN
General Agent Savoy Associates		Agent ID # NJGA06853

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Instructions and Eligibility Requirements

Instructions

- Except for Section G, you must complete Sections A through I, and sign and date this form and 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 indicate this in Section A by checking the applicable box in the Add section and identifying the applicable Triggering Event under "Reason."
- 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 find a provider's name, address, and NPI or Provider ID number using the provider directory or by contacting the provider. Provider groups with multiple office locations and individual providers who belong to more than one practice or provider entity may have more than one NPI or Provider ID #. Be sure to confirm the correct information 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 4-digit extension (9 digits).
- If you have questions concerning the benefits and services provided by or excluded under this policy, call 1-800-877-9829 before signing this form.
- KEEP A COPY OF THIS COMPLETED APPLICATION! Coverage must be verified with AmeriHealth prior to using your benefits. You may also register for your secure member account at amerihealth.com and print a temporary ID card that is valid for 10 days.
- Triggering Events:
  Please note: You must provide evidence of the triggering event with your enrollment form.

1. Loss of eligibility for minimum essential coverage but not lost due to nonpayment of premium
2. Voluntary or involuntary non-renewal of a non-calendar year plan
3. Loss of pregnancy-related coverage or access to health care services through coverage for your unborn child
4. Dependent attained age 26 or 31 and lost coverage
5. You are no longer eligible for a tax credit (subsidy)
6. Marriage (at least one spouse must have had coverage for at least 1 day within the prior 60 days)
7. Confirmation of pregnancy by health care provider
8. Birth, adoption or placement for adoption, placement in foster care, or child support order or other court order, but only you and the new dependent are eligible for the special enrollment
9. Became eligible for 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)
10. Application to NJ FamilyCare submitted during Open Enrollment Period or during a Special Enrollment Period is found ineligible
11. Domestic abuse or spousal abandonment necessitating coverage apart from the perpetrator
12. Erroneous enrollment or non-enrollment due to error, misrepresentation, misconduct, or inaction of entity providing enrollment assistance or a carrier's violation of a material provision of the plan in relation to a covered person
13. Your effective date under a health reimbursement arrangement known as either an ICHRA or QSEHRA
14. Eligible for different plans as a result of moving to a different county within New Jersey (must have had coverage at least 1 day within the prior 60 days)

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 for the Catastrophic plan, the following additional requirements apply:
   1. You must be younger than 30; 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.

The annual **Open Enrollment Period** begins November 1 and ends January 31 each year. This is the designated period of time during which you may apply for or change coverage for yourself and family members who are currently uninsured, covered under another individual plan, or covered under a group health plan, group health benefits plan, governmental plan, or church plan. Your application must be signed, dated, and mailed during the Open Enrollment Period. The effective date of coverage if you apply by December 31 will be January 1 of the immediately following year. The effective date of coverage if you apply between January 1 and January 31 will be February 1 of the same year.

A **Special Enrollment Period** lasts for 60 days following 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 also 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; however you SHOULD NOT terminate it until the new coverage is effective.

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Conditions of Enrollment — *Subscriber 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 understand that my enrollment and the enrollment of my listed dependents in an AmeriHealth individual plan is subject to acceptance by AmeriHealth.
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 on time.

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.

AmeriHealth