AmeriHealth NEW JERSEY

SEH Group Application

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:
Send to your AmeriHealth New Jersey Account Executive

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/Apt		
Street/Apt	City	
State	Zip Code	Phone
Email Address	Facsimile	
Main Address		
Street/Apt		
Street/Apt	City	
State	Zip Code	Phone
Email Address	Facsimile	
Contract information should be provided. Check one ☐ electronically ☐ hard copy		
4. Type of Organization ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ 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 ☐ 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 coverage of children of a covered domestic partner? ☐ Yes ☐ No		
10. Is the employer 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): The ☐ 1st or ☐ 15th of the month following the waiting period of: ☐ 0 days ☐ 30 days ☐ 60 days ☐ exactly 90 days for: ☐ Present Employees_____ ☐ New Employees_____ ☐ Rehired Employees_____		
14. Period for Annual Employee Open Enrollment.		
15. What percentage of the total 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 full-time employees in this company	Number of full-time employees in this company

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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.

All AmeriHealth New Jersey Small Group plans are offered with a calendar year benefit period. Only certain Small Group plans are offered with a plan year benefit period. When selecting an AmeriHealth New Jersey Small Group plan, place a check mark next to your plan of choice to indicate the benefit period option of calendar year or plan year (if applicable).

To view the Summary of Benefits and Coverage (SBC) for your plans, visit amerihealthexpress.com or call 1-888-YOUR-AH (1-888-968-7241) (TTY:711) to request a paper copy.

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

Bronze Portfolio		
Calendar Year	**Plan Year**	
☒	☐	SELECT EPO HSA Local Value $50/$75

Silver Portfolio		
Calendar Year	**Plan Year**	
☐	☐	SELECT EPO HSA Local Value 0%/0%
☐	☐	SELECT EPO HSA Regional Preferred 0%/0%
☐	☐	HMO Local Value $50/$75
☐	☐	HMO Regional Preferred $50/$75
☐	☐	EPO HSA Local Value 0%/30%
☐	☐	EPO HSA Regional Preferred 0%/30%
☐	☐	EPO HSA Local Value 20%/20%
☐	☐	EPO HSA Regional Preferred 20%/20%
☐	☐	EPO HSA Local Value 0%/5%
☐	☐	EPO HSA Regional Preferred 0%/5%
☐	☐	SELECT EPO Local Value $50/$75

Gold Portfolio		
Calendar Year	**Plan Year**	
☐	☐	SELECT EPO HSA Local Value 0%/0%
☐	☐	SELECT EPO Local Value $30/$60
☐	☐	SELECT EPO Regional Preferred $30/$60
☐	☐	EPO HSA Regional Preferred 0%/20%
☐	☐	EPO HSA Local Value 0%/0%
☐	☐	EPO HSA Regional Preferred 0%/0%
☐	☐	EPO Local Value $30/$60
☐	☐	EPO Regional Preferred $30/$60
☐	☐	EPO National Access $30/$60
☐	☐	EPO HSA National Access 10%/10%
☐	☐	HMO Regional Preferred $30/$65

Platinum Portfolio		
Calendar Year	**Plan Year**	
☐	☐	EPO Regional Preferred $10/$30
☐	☐	EPO National Access $10/$30

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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 ☐ SEH Family Plus 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 your marketing representative.

☐ 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
Effective date for current Pediatric Dental coverage	Group Dental Policy Number

Section III: All questions must be answered

1. 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, give 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 Employess/Dependent	Date of Birth	Type of Continuation State/ Federal/Extended Benefits	Reason for Termination Disability/Other	Continuation Dates

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.

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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.

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