GROUP ENROLLMENT/CHANGE REQUEST

HEALTH REPUBLIC INSURANCE

Group Information – to be completed by Employer:

Health Republic Insurance of New Jersey	Group Name:	Group Number:	Class Code:

A. Type of Activity – to be completed by Employer. *Refer to instructions page 7 before completing this form. Print clearly.*

	Activity – Check all that apply	Effective Date/Date of Event	Date of Hire/Reason for Change
1. ADD	☐ Enrollment of a new Enrollee ☐ Add Spouse/Civil Union Partner ☐ Add Domestic Partner ☐ Add Dependent Child ☐ Add Over-Age Child as a Dependent Under 31 *(and complete section A 4)*	_____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____	Date of Hire: _____/_____/_____ _____ _____ _____ _____
2. REMOVE	☐ Employee Withdrawal/Termination ☐ Remove Spouse/Civil Union Partner ☐ Remove Domestic Partner ☐ Remove Dependent Child ☐ Remove Over-Age Child as a Dependent Under 31	_____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____	_____ _____ _____ _____ _____
3. OTHER CHANGE	☐ Name Change ☐ Change Plan ☐ Other ☐ Add/Change Office ID Numbers: Primary/OB/Gyn/ Dentist	_____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____	_____ _____ _____ _____

4. COVERAGE CONTINUATION

☐ For Employee
- ☐ Total Disability*
- ☐ COBRA/NJSGC
  - Length of Continuation (in months):
  - ☐ 18 ☐ 29
  - Date of Loss of Coverage: ___/___/___
  - Qualifying Event #:_____**
  - Date of Qualifying Event: ___/___/___

Billing: ☐ Group ☐ Home (Section B)

**Attach proof of disability*

☐ For Spouse/Civil Union Partner*
- Length of Continuation (in months):
- ☐ 18 ☐ 36
- Date of Loss of Coverage: ___/___/___
- Qualifying Event #:_____**
- Date of Qualifying Event: ___/___/___

Billing: ☐ Group ☐ Home (what address?)
- ☐ Section B *OR*
- ☐ Section E

**Civil union partners are eligible to make an election pursuant to NJSGC, if applicable.*

☐ For Dependent or Over-age Child
- ☐ COBRA/NJSGC
  - Length of Continuation (in months):
  - ☐ 18 ☐ 36
  - Loss of Coverage: ___/___/___
  - Qualifying Event #:_____**
  - Date: ___/___/___
- ☐ Dependent Under 31
  - Qualifying Event #:_____**

Billing: ☐ Group*** ☐ Home (what address?)
- ☐ Section B *OR* ☐ Section F

***Qualifying event #s: see list in Instructions. ***Billing through the group for a Dependent Under 31 Continuation Election requires agreement by the employer at Section J.*

B. Employee Information – to be completed by the Employee	Name (Last, First, MI):	SSN:

Home

Street/Apt:_____
Street/Apt:_____
City:_____ State:_____ Zip Code: _____

Birthdate (mm/dd/yyyy): ☐ Male ☐ Female

Phone: (_____)_____
Email: _____

Work

Employer Name:_____
Address:_____
City:_____ State:_____ Zip Code: _____

Phone: (_____)_____
Email:
_____
Employment Date: _____/_____/_____
Hours worked per week:_____

Activity

☐ Add ☐ Remove ☐ Continuation ☐ Other Change *If a name change, indicate prior name:*

Primary Loc #:_____ NPI #: Current Patient: ☐ Yes ☐ No
address: zip+4

Ob/Gyn Loc #:_____ NPI #: Current Patient: ☐ Yes ☐ No
address: zip+4

Dentist Loc #:_____ NPI #: Current Patient: ☐ Yes ☐ No
address: zip+4

Other Health Coverage? ☐ Yes ☐ No *If yes:*
Payer Name: _____
Policy #: _____
Medicare ID#, if any: _____

Other Rx Coverage? ☐ Yes ☐ No *If yes:*
Payer Name: _____
Policy #: _____
Medicare ID#, if any: _____

C. Plan Option – to be completed by the Subscriber - *Check one.*

Medical Plan options

Health Republic Full Access:

☐ PrimeBronze
Deductible – $2,500 (individual)/$5,000 (family)

☐ PrimeSilver
*Deductible – $2,000 (individual)/$4,000 (family)
*1st Four PCP visits $0 Cost Share

☐ PrimeGold
Deductible – $1,750 (individual)/$3,500 (family)

☐ SolidBronze (**HSA**)
Deductible – $2,500 (individual)/$5,000 (family)

☐ SolidSilver (**HSA**)
Deductible – $2,000 (individual)/$4,000 (family)

☐ SolidGold
Deductible – $1,500 (individual)/$3,000 (family)

☐ CoreSilver
Deductible – $2,000 (individual)/$4,000 (family)

☐ CoreGold
Deductible – $1,500 (individual)/$3,000 (family)

☐ CorePlatinum
Deductible – $750 (individual)/$1,500 (family)

Health Republic Full Access:

☐ PureBronze
Deductible – $2,500 (individual)/$5,000 (family)

☐ PureSilver
Deductible – $2,000 (individual)/$4,000 (family)

☐ PureGold
Deductible – $1,800 (individual)/$3,600 (family)

☐ PurePlatinum
Deductible – $0 (individual)/$0 (family)

Health Republic Monmouth County Community Plan:

☐ Bronze

Tier 1 Bronze: Deductible – $1,500 (individual)/$3,000 (family)

Tier 2 Bronze: Deductible – $2,500 (individual)/$5,000 (family)

☐ Silver

Tier 1 Silver: Deductible – $0 (individual)/$0 (family)

Tier 2 Silver: Deductible – $2,500 (individual)/$5,000 (family)

☐ Gold

Tier 1 Gold: Deductible – $0 (individual)/$0 (family)

Tier 2 Gold: Deductible – $2,500 (individual)/$5,000 (family)

☐ Platinum

Tier 1 Platinum: Deductible – $0 (individual)/$0 (family)

Tier 2 Platinum: Deductible – $1,500 (individual)/$3,000 (family)

Health Republic Active Access Spotlight Plan:

☐ Bronze

Tier 1 Bronze: Deductible – $2,500 (individual)/$5,000 (family)

Tier 2 Bronze: Deductible – $2,500 (individual)/$5,000 (family)

☐ Silver

Tier 1 Silver: Deductible – $2,000 (individual)/$2,000(family)

Tier 2 Silver: Deductible – $2,000 (individual)/$4,000 (family)

☐ Gold

Tier 1 Gold: Deductible – $1,500 (individual)/$3,000 (family)

Tier 2 Gold: Deductible – $1,500 (individual)/$3,000 (family)

☐ Platinum

Tier 1 Platinum: Deductible – $0 (individual)/$0 (family)

Tier 2 Platinum: Deductible – $0 (individual)/$0 (family)

D. Other Individuals Covered – to be completed by the Employee. *Identify individuals other than yourself for whom you are adding/changing/removing/continuing coverage. Attach additional pages if necessary, with your signature and dated. Attach proof of disability.*

1. Spouse; Domestic or Civil Union Partner	**2.Child**	**3. Child**	**4. Child**
☐ Add ☐ Remove ☐ Other ☐ Continue Spouse ☐ Continue CU Partner (NJSGC)	☐ Add ☐ Remove ☐ Other ☐ Continue	☐ Add ☐ Remove ☐ Other ☐ Continue	☐ Add ☐ Remove ☐ Other ☐ Continue
Name (last, first, MI) L:_____ F:_____ MI:	Name (last, first, MI) L:_____ F:_____ MI:	Name (last, first, MI) L:_____ F:_____ MI:	Name (last, first, MI) L:_____ F:_____ MI:
Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):
☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Social Security Number:	Social Security Number:	Social Security Number:	Social Security Number:
Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name: _____ Policy #: _____ Medicare ID #:	Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name: _____ Policy #: _____ Medicare ID #:	Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name: _____ Policy#:_____ Medicare ID #:	Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name: _____ Policy #: _____ Medicare ID #:
Other Rx Coverage: ☐ Yes ☐ No *If yes:* Payer Name:_____ Policy #: _____ Medicare ID #:	Other Rx Coverage: ☐ Yes ☐ No *If yes:* Payer Name:_____ Policy #: _____ Medicare ID #:	Other Rx Coverage: ☐ Yes ☐ No *If yes:* Payer Name:_____ Policy #: _____ Medicare ID #:	Other Rx Coverage: ☐ Yes ☐ No *If yes:* Payer Name:_____ Policy #: _____ Medicare ID #:

Primary Care Provider: NPI#:_____ Address:_____ _____ zip+4 Current Patient? ☐ Yes ☐ No	Primary Care Provider: NPI:_____ Address:_____ _____ zip+4 Current Patient? ☐ Yes ☐ No	Primary Care Provider: NPI#:_____ Address:_____ _____ zip+4 Current Patient? ☐ Yes ☐ No	Primary Care Provider: NPI#:_____ Address:_____ _____ zip+4 Current Patient? ☐ Yes ☐ No
Ob/Gyn Office NPI#:_____ Address:_____ _____ zip+4 Current Patient? ☐ Yes ☐ No ☐ NA	Ob/Gyn Office NPI#:_____ Address:_____ _____ zip+4 Current Patient? ☐ Yes ☐ No ☐ NA	Ob/Gyn Office NPI#:_____ Address:_____ _____ zip+4 Current Patient? ☐ Yes ☐ No ☐ NA	Ob/Gyn Office NPI#:_____ Address:_____ _____ zip+4 Current Patient? ☐ Yes ☐ No ☐ NA
Employed? ☐ Yes ☐ No *If yes, complete Section E.*	If last name is different from Employee's, please explain: _____ _____	If last name is different from Employee's, please explain: _____ _____	If last name is different from [Employee's], please explain: _____ _____
Home or billing address same as Employee? ☐ Yes ☐ No *If NO, complete Section E2*	Living with Employee? ☐ Yes ☐ No *If NO, complete Section F*	Living with Employee? ☐ Yes ☐ No *If NO, complete Section F*	Living with Employee? ☐ Yes ☐ No *If NO, complete Section F*

E. Additional Spouse/Civil Union Partner/Domestic Partner Information – to be completed by Employee. If *not applicable, please mark as "NA."*	1. Employer Name:_____ Employer Address:_____ City, State, Zip Code:_____ Employer Phone: ( )
2a. Street/Apt:_____ Street/Apt:_____ City, State, Zip Code:_____	2b. Please explain why the address is different: _____ _____

F. Additional Child Information – to be completed by Employee. *Provide information below about children listed in Section D,* **if** *they have a different address from the employee. 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, ZipCode:_____
Reason:_____

Name(s):_____
Street/Apt:_____
Street/Apt:_____
City, State, Zip Code:_____
Reason:_____

G. Race/Ethnicity – to be completed by the Employee, at his/her option.
NOTE: *your response is appreciated but NOT required!*

Choose a category that most closely describes you:

☐ American Indian or Alaskan Native ☐ Black, not of Hispanic origin ☐ Hispanic
☐ Asian or Pacific Islander ☐ White, not of Hispanic origin

H. Employee 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. I authorize deductions from my earnings for any contributions required from me.

Signature: _____ Date: _____

I. Over-Age Child's Signature

I represent that all the information supplied in this application regarding the Dependent Under 31 Continuation Election is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I hereby agree to make contributions required from me for the Dependent Under 31 Continuation Election.

Signature: _____ Date: _____

J. Employer Verification

The requested activity is believed eligible and is approved by the Employer. In addition, the Employer consents to payroll deduction for Dependent Under 31 Continuation Election: ☐ Yes ☐ No

Employer Representative: _____ Date: _____

Representative's Title: _____

INSTRUCTIONS

Employers – You must complete the Employer Group Information and sections A and J in order for this application to be processed.

Employees – You must complete sections A through H and submit the signature of each Over-Age Child for which a Dependent Under 31 Continuation Election is made in accordance with Section I in order for this application to be processed.

- Please PRINT except when a signature is requested.
- If a dependent is disabled and you want to continue his or her coverage beyond age 26, you do not have to make a COBRA/NJSGC or Dependent Under 31 election. Instead, select "Other" in Section A3, and attach proof of disability.
- For provider addresses, include the zip code plus the four digit extension (11 digits)
- You can obtain the providers' correct names and addresses from the appropriate provider directory. You may also obtain each provider's NPI number by contacting the provider directly. Providers with multiple office locations and individual providers who belong to more than one practice or provider entity may have more than one NPI number. You should confirm the correct NPI number for the specific provider and office location where you will be seen by contacting that office directly.

Qualifying Events

COBRA and NJSGC

C1. Termination of job or reduction in hours
C2. Employee enrollment in Medicare (COBRA only)
C3. Divorce (COBRA/NJSGC); civil union dissolution (NJSGC)
C4. Death of employee
C5. Loss of dependent child status under the plan
C6. Disability (occurring subsequent to another qualifying event)

Dependent Under 31

D1. Loss of dependent status and otherwise eligible
D2. Reestablish eligibility: residency
D3. Reestablish eligibility: nonresident full-time student
D4. Reestablish eligibility: change in marital status
D5. Reestablish eligibility: change in parental status
D6. Reestablish eligibility: termination of other coverage

CONDITIONS OF ENROLLMENT -- APPLICANT ACKNOWLEDGEMENTS 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 or other medical care institution, carrier, consumer reporting agency, and any employer to give Health Republic Insurance of New Jersey, or any consumer reporting agency acting on behalf of Health Republic Insurance of New Jersey, 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 Health Republic Insurance of New Jersey 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 Health Republic Insurance of New Jersey will provide coverage in accordance with the terms of the contract for the group plan policy.
5. 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 group plan policy if premiums are not paid timely. I authorize my Employer to withhold payments from my wages as contribution to the premium, as appropriate.