AmeriHealth NEW JERSEY

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

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/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 Correspondent		
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

SEH Group Application

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).

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

Bronze Portfolio		
Calendar Year	**Plan Year**	
☐	☐	EPO HSA Local Value $50/$75
☐	☐	EPO HSA Regional Preferred $50/$75
☐	☐	EPO HSA Tier 1 Advantage $50/$75
☐	☐	EPO HSA AmeriHealth Advantage $25/$50
Silver Portfolio		
Calendar Year	**Plan Year**	
☐	☐	POS Plus Local Value $50/$75
☐	☐	POS Plus Regional Preferred $50/$75
☐	☐	HMO Local Value $50/$75
☐	☐	HMO Regional Preferred $50/$75
☐	☐	EPO HSA Tier 1 Advantage $50/$75
☐	☐	EPO AmeriHealth Advantage $30/$60
☐	☐	EPO Local Value $30/$60/50% Coins
☐	☐	EPO Regional Preferred $30/$60/50% Coins
☐	☐	EPO HSA Local Value 90%/90%
☐	☐	EPO HSA Regional Preferred 90%/90%
☐	☐	EPO HSA Local Value 100%/100%
☐	☐	EPO HSA Regional Preferred 100%/100%
☐	☐	EPO HSA Local Value 80%/80%
☐	☐	EPO HSA Regional Preferred 80%/80%
Gold Portfolio		
Calendar Year	**Plan Year**	
☐	☐	EPO Local Value $30/$50/80% Coins
☐	☐	EPO Regional Preferred $30/$50/80% Coins
☐	☐	EPO National Access $30/$50/80% Coins
☐	☐	HMO Regional Preferred $30/$60, Rx 50%/$125 Max
☐	☐	POS Plus Regional Preferred $30/$60
☐	☐	POS Plus National Access $30/$60
☐	☐	EPO HSA Local Value 100%/100%
☐	☐	EPO HSA Regional Preferred 100%/100%
☐	☐	EPO Tier 1 Advantage $30/$50
☐	☐	EPO AmeriHealth Advantage $10/$20
☐	☐	EPO HSA National Access 90%/90%
Platinum Portfolio		
Calendar Year	**Plan Year**	
☐	☐	HMO Regional Preferred $15/$30
☐	☐	POS Plus Regional Preferred $15/$30
☐	☐	POS Plus National Access $15/$30

AmeriHealth NEW JERSEY

SEH Group Application

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
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.

SEH Group Application

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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Language Taglines and Nondiscrimination Notice

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意：如果您讲中文，您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કોલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic:
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考：母国語が日本語の方は、言語アシスタンスサービス（無料）をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):
توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh. Hódíílnih kojį' 1-800-275-2583.

Urdu:
توجہ درکارہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583.

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

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(OVER)

Language Taglines and Nondiscrimination Notice

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscoordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

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