Enrollment / Change Form (For all plans including NJ Small Group Employer Benefits Program)

AmeriHealth NEW JERSEY

12830

1 Plan Selection

1A Standard Plans (Indicate co-pay amount and deductible) **1B**

POS+ 10/20	EPO 30/50	PPO HSA	EPO HSA								

2 Subscriber/Member Enrollment or Change - Employee Must Complete in Full

- ☐ **New Application**
  - ☐ New Hire
  - ☐ Open Enrollment
  - ☐ Life Event Change

  Complete all information and sign form.
- ☐ **Information Change** Provide your Identification Number below and indicate the change(s) you are making. Complete Appropriate section(s) and sign at bottom of form

  I.D. # _____
- ☐ **Change**
  - ☐ Address
  - ☐ Last Name
  - ☐ Primary Care Office
  - ☐ Rehire
- ☐ **Dependent Membership Change**
  - ☐ Add Dependent
    - If adding spouse, indicate marriage date __/__/__
  - ☐ Delete Dependent
- ☐ **Other Change**
  - ☐ COBRA ☐ Conversion
  - ☐ 18 mos. eff. date: ___/___/___
  - ☐ 29 mos. eff. date: ___/___/___
  - ☐ 36 mos. eff. date: ___/___/___
- ☐ **Terminate Contract**
  - ☐ Terminated Employment
  - ☐ Full-time to Part-time
  - ☐ Deceased, date: ___/___/___
  - ☐ Open Enrollment

3 Subscriber Information

NOTE: Please complete this section in its entirety, whether you are a new applicant or are making a change

Social Security Number	Last Name	First Name	Middle Initial	Sex	Date of Birth month / day / year
				☐ M ☐ F	___/___/___

Street Address | City | State | Zip Code

Telephone Number (including area code) Home: ( ) - Work: ( ) -

Employment Status: ☐ Active ☐ Retiree ☐ COBRA

Marital Status: ☐ single ☐ married ☐ divorced ☐ separated

Previous Health Insurer

3A Group/Employer Information

Your **Group Administrator** must complete this section. This form cannot be processed without this information.

☐ Check if National Account

Group Number | Group Name: Brookfield Schools

Account Number | Group Address

Employer Signature and Date

Date of Hire ___/___/___

Payroll/Work Location | Location Name/Phone #

3B Complete this section for HMO or POS Only

Primary Care Office Name | If Current Physician Check This Box ☐

Primary Care Office 10 Digit HMO Identification Number

4 Dependent Information

Please provide all information for each person to be covered.

4A For HMO/POS Only

4B

4C

Last Name	First Name	Middle Initial	Sex (M/F)	Date of Birth Month/day/year	Social Security Number	Primary Care Office Name	Primary Care Office Number (If current Physician, check box at right.)	If Disabled Please Attach Verification
Spouse							☐	☐ Yes ☐ No
Child							☐	☐ Yes ☐ No
Child							☐	☐ Yes ☐ No
Child							☐	☐ Yes ☐ No

If you have listed any dependents in the Dependent Information Section, you must answer the question below.

Do any of the dependents listed in this section live at another address?

☐ Yes ☐ No

If yes, who and what address?

If any dependent's last name is different from yours, eplain the circumstances.

Please use the reverse side.

5 Other Insurance Information

To be sure that you receive all the benefits to which you are entitled, you must complete the following.

5A

5B Are you or any of your dependents currently receiving Medicare benefits? ☐ Yes ☐ No If yes, please give name of recipient.

	Part A (Y/N)	Effective Date	Part B (Y/N)	Effective Date	Medicare Claim #
Self					
Spouse					
Child					

5C When you become effective with your policy, will any persons listed on this enrollment form be covered by any other health insurance policy. ☐ Yes ☐ No

If yes, please give name and policy number of insurance carrier and type of benefits.

Ins. Co. Name _____

Policy Number _____

Policy Holder _____

Type of benefits: ☐ Health ☐ RX ☐ Dental ☐ Vision

Who is covered by this policy? List names of those covered.

(1) _____

(2) _____

(3) _____

(4) _____

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Signature of Employee | Date Signed

*Print as clear as possible in all areas.