

Send to: AmeriHealth Enrollment

1	Plan (please specify Fast Track or Standard)													
1A	Standard Plans (Indicate co-pay amount and deductible) 1B Fast Track (Circle co-pay)													
HN	Ю	POS	OS PPO CMM Rx Vision Denta						HMO POS PPO					90
								\$10 \$20		\$20	\$10	\$20	\$10	\$20

	New Jersey Small Group nefits Program	Philadelphia, PA	19101	-2555							\$10	\$20	\$10	\$20	\$10 \$20
2 Subscrib	er/Member En	rollment or (Chan	ge - Em	ployee Mus	t Com	plete in F	ull							
□ New Application □ New Hire □ Open Enrollmen □ Life Event Chan Complete all informati and sign form.	 Information Cha Provide your Ider indicate the change appropriate section 		low and g. Comp	Chan Aplete La corm. P		☐ Depe Chan ☐ Add If ad mai	ndent Membe	rship indicate	□ 29	BRA mos. mos.	•	nversion // // //	□ Terr □ Full □ Dec	-time to Pa ceased, dat en Enrollme	mployment art-time te://
3 Subscrib	er Information	NOTE: Please or are making			on in its entirety, wh	nether yo	u are a new ap	plicant		3 <i>F</i>	Group/	Employ	er Ir	nforma	tion
Social Security Number Street Address	Last Nam	9	First Na			liddle Initia	Sex M F Zip Code		nte of Birth nth/day/year / /	Th	our Group Adn nis form canno Check if Nati	ninistrator r t be proces onal Accou	must co sed wit	mplete this thout this ir	s section.
Sileet Address			Jity		State		Zip Code			Gio	oup Number	Group Nan	ne (Fuii i	_egai Name	or Company)
Telephone Number (include area code) Ho	me: () —	Emple □ Act □ Re			farital Single Status Separate			ıs Health	Insurance	Acc	count Number	Group Add	Iress		
	e this section			Only						Em	ployer Signature	and Date			
											Date of Hi	ire	Date C	overage/Cha	ange is Effective
Primary Care Office Nan	ne If Current Phys	sician Check This Box [<u> </u>	Primary Ca	are Office Code Numb	oer				<u> </u>	// Payroll/Work L			n Name/Pho	
Primary Dental Office Na 4 Depende	nt Information	ist Check This Box - Please provide a	ll inform	,			Primary Care Of		POS On	-	4B Verifi Overage Student	cations	4 (C ou have listed	any dependents in th
Last Name	First Name	Middle Initial	Sex	Month/day/ye		Number	Name If current physicia	an, check b	Number oox at right.		Please attach	Please attach			nation Section, you e questions below.
Spouse			□ м □ ғ						Ţ.		verification.	verification		tion live at and	pendents listed in this other address? ☐ No
Child			□ м □ ғ								□ Yes □ No	□ Yes □ No		es, who and at plain the circun	t what address? mstances:
Child			<u>э</u> г Эм								□ Yes □ No	□ Yes □ No	If a	nv dependent'	's last name is differer
Child			□ м □ ғ								□ Yes □ No	□ Yes □ No	fror	1 yours, explai	in the circumstances:
5 Other Ins	surance Inform	ation To be sur	e that yo	ou receive al	I the benefits to wh	nich you a	re entitled, you	u must c	omplete the	follo	wing:				
If yes, please of	employed? ☐ Yes live name, address, an of spouse's employer	□ No d				50	any persons	s listed o any othe	effective with on this enroll or health ins	ment	t form be	Who is cove of those cov		this polic	cy? List names
Yes		e give name of recip	ient.		CARE CLAIMANUI	4DED	If yes, pleas insurance o	se give n arrier an	d type of be	nefit	s.	2)			
PARTA SELF □ Yes □ No		PART B EFFEC	TIVED	ATE MEDIC	SARE CLAIM NUM	IBER	Policy Num								
SPOUSE Yes No		□ Yes □ No -					Policy Hold	er			(3)			
CHILD □ Yes □ No		⊒Yes ⊒No -	-				Type of ber ☐ Health ☐		ption □ De	ntal	☐ Vision (4)			

Important: Please read the back of this form, then sign below.

	COMPLETE THIS SECTION IF APPLYING FOR	COVERAGE UNDER THE NEW JERSEY SM	ALL EMPLOYER HEALTH BENEFITS PF	ROGRAM ONLY.
Occupation:	Title:	Date of Employment:	Hours Worked Per Week:	Are you actively at work? Yes N
enrollment within 30 days after you	yourself or your dependents (including your spouse) be ir other coverage ends. In addition, if you have a new of after the marriage, birth, adoption, or placement for add	dependent as a result of marriage, birth, adoption, or		
Persons to be covered:	oyee Only	☐ Employee & Spouse ☐ Employee,	Spouse & Child(ren)	
Which coverage have you selected	d to be primary in the event expenses are incurred as a	result of an automobile related injury? Auto	Medical	
Are you replacing existing coverage	e? Yes No If "Yes", give the name and p	olicy number of the replaced carrier, the effective and	termination dates, and the name(s) of the person	ons covered by the policy
	be covered, covered under a prior Group Health Plan? ndents to be covered, may be required to satisfy the pre		f Group Health Plan Coverage. Please note tha	at if you do not provide the Certificate of Group Healt
	ECLARATION AUTHORIZATION AND CONDIT	TONS OF ACCEPTANCE FOR THE NEW JER	SEY SMALL EMPLOYER HEALTH BENE	FITS PROGRAM

I hereby enroll for the group coverage to which I am or may be entitled. I authorize deductions from my pay for my share of the cost, if any.

I represent that to the best of my knowledge and belief, the statements and answers given above are true and complete. I understand that the information shall form the basis upon which I may be included for coverage under the group plan.

Lunderstand that:

- a) the coverage applied for will not take effect unless:
 - after review of this Enrollment Form, AmeriHealth accepts it;
 - the first premium has been paid to AmeriHealth; and

- I am either actively at work for full pay on a full-time basis on the date coverage is to take effect, or subject to applicable regulations,
 I qualify under a waiver of the active work requirement
- b) no person, except an officer of AmeriHealth has authority to: determine whether certificate/evidence of coverage shall be issued based on this Enrollment Form, waive or modify any of the provisions of the Enrollment Form, or any of the AmeriHealth Requirements; to bind AmeriHealth by any statement or promise pertaining to any certificate/evidence of coverage to be issued on the basis of this Enrollment Form; or accept any information or representation not contained in the written Enrollment Form
- c) the Employer is hereby designated my representative for the purpose of receiving contributions and remitting them to AmeriHealth.
 - AmeriHealth does not pay benefits for charges, or provide services or supplies related to a preexisting condition for 180 days, measured from the enrollment date. I understand that a Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a person's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date. I also understand that New Jersey Law only permits the application of the preexisting conditions limitation under certain circumstances and that I or my dependents will only be subject to this limitation to the extent permitted by New Jersey Law.

I understand that by signing below when I file a claim, AmeriHealth may pay the health care benefits directly to the provider instead of to me.

I state that I am a resident of New Jersey and I live, reside or work within AmeriHealth's service area. I understand that if I omit or falsify any statement on this enrollment form, AmeriHealth can cancel my coverage as of the original effective date

Any person who includes any false or misleading information on an application or enrollment form and change form for a health benefits plan is subject to criminal and civil penalties.

Note: A person who was covered under Creditable Coverage has a right to request a certificate from the prior plan or issuer to demonstrate that he or she was covered under Creditable Coverage. If necessary, AmeriHealth will assist the person in obtaining a certificate from the prior plan or issuer.

Conditions of Acceptance

On behalf of myself and the dependents listed on this Enrollment Form. I agree to or with the following:

- 1. Employee is applying for coverage for the employee, employee's spouse and any eligible unmarried children under nineteen (19) years of age, unmarried children who are mentally or physically incapacitated and who are chiefly dependent upon the employee or the employee's spouse for support and maintenance or are unmarried children between the ages of nineteen (19) and twenty-three (23) who are enrolled as full-time students at an accredited school.
- 2. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the Contract.
- 3. The Contract will determine the rights and responsibilities of members and will govern in the event it conflicts with any benefits comparison, summary or other description of the health benefits plan.
- 4. As a condition to receiving in-network benefits, employee understands and agrees that with the exception of emergency procedures as defined in the Contract all in-network services, in order to be covered by AmeriHealth, must be performed either by a participating primary care physician or by the participating specialist, hospital or other provider as authorized by prior written referral from the participating primary care physician. Out-of-network benefits are covered, as stated in the contract
- 5. Employee agrees to make payment directly to health care providers such copayments as are provided in the employer's health benefits plan.
- 6. Employer understands that this coverage will remain in effect regardless of the continued availability of a particular primary care physician.
- 7. Employee acknowledges that AmeriHealth's participating providers, including all participating primary care physicians, are independent contractors and are not agents or employees of AmeriHealth.

Authorization

- 1. I authorize the sources stated below to give to AmeriHealth, or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, advice, treatment or supplies for any physical or mental condition. Authorized sources are: any physician or medical professional; any hospital, clinic or other medical care institution; any carrier; any consumer reporting agency: any employer.
- 2. I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which AmeriHealth has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months. if not revoked earlier.
- 3. I know that I have a right to receive a copy of this authorization if I request one.
- 4. I agree that a photocopy of this authorization is as valid as the original.

I understand that if I choose an HMO Product the provision of services to me and my dependents as Members of AmeriHealth is governed by the applicable Group Master Contract, which provides that: 1) except for emergencies, all medical or dental care must be initialed at the primary care office or primary dental office (as appropriate) we have selected; and 2) and my dependents authorize any person or organization providing services to furnish AmeriHealth with medical or dental records or other information concerning such services for purposes of AmeriHealth quality and utilization review. I understand that if I choose a Point of Service Product, I will be subject to applicable deductible, coinsurance and other copayments for all non-referred services, as specified in the contract. I further understand that I can change health plan coverage only at the time my employer and AmeriHealth specify.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any material false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.



ENROLLMENT/CHANGE FORM

Send to: AmeriHealth Enrollment P.O. Box 42555 Philadelphia PA 19101-2555

1	Plan (please specify Fast Track or Standard)													
1A	1A Standard Plans (Indicate co-pay amount and deductible) 1B Fast Track (Circle co-pay)													
HN	ИΟ	POS	PPO	CMM	Rx	Vision	Dental	HMO			POS		PF	,O
								\$10	0	\$20	\$10	\$20	\$10	\$20

Employer Bene	efits Program	Philadelphia, PA	19101	-2555												
2 Subscribe	er/Member Er	rollment or 0	Chan	ge - Er	mploy	yee Must	Comp	lete in	Full							
☐ New Application☐ New Hire	☐ Information Cha Provide your Ider	nge ntification Number be	low and	☐ Cha	ange I Addres	s	Change		ership	☐ Othe ☐ CO	BRA	. □ Cor	version		nate Contract minated Emplo	yment
☐ Open Enrollment☐ Life Event Chang☐	e appropriate secti	ge(s) you are making on(s) and sign at bot	-	form. 🗆	Last Na Primary Rehire	ame	If addi	ependent ng spouse ge date _		□ 29	mos.	. eff. date:/ . eff. date:/ . eff. date:/	/	☐ Dec	-time to Part-ti	me //
Complete all informatio and sign form.	n I.D. #				Dental	Office	□ Delet	e Depende	ent	3 30	11103.	. en. date/		☐ Oth	en Enrollment er:	
3 Subscribe	er Informatio	n NOTE: Please or are making a					her you a	ire a new a	applicant		3/	Group/	Employ	er In	formatio	n
Social Security Number	Last Nam		First N		isting co		lle Initial	Sex D M	/ m	Oate of Birth onth/day/year	Th	our Group Adm nis form cannot Check if Natio	inistrator r be proces	nust co sed wit	mplete this sed	ction.
Street Address	•	(City			State		Zip Code	•	, ,		oup Number			_egal Name of C	ompany)
Telephone Number (include area code) Hom Work	e: () —	Emplo □ Act □ Re		Status D COBRA	Marital Status	☐ Single☐ Separated☐ Widowed	☐ Divorc ☐ Marrie		ous Health	n Insurance	Acc	count Number	Group Add	ress		
	this section			Only							Em	ployer Signature	and Date		,	
Primary Care Office Name	e If Current Phy	sician Check This Box [<u> </u>	Primary	Care Off	ice Code Number						Date of Hir	е	Date Co	overage/Change	is Effective
Primary Dental Office Nan	•	tist Check This Box 🖵	_									Payroll/Work Lo	ocation	Location	n Name/Phone #	<u></u>
	nt Information		ll inform			ffice Code Numberson to be cover		A For	нмо	/POS On		4B Verific	rations	40	e e	
Full Name Last Name	First Name	Middle Initial	Sex	Date of E	Birth	ocial Security Nu	P	rimary Care Name	Office P	rimary Care Office Number to box at right.	4	Overage Student? Please	Disabled Please	? If yo	ou have listed any opendent Information st answer the que	n Section, you
Spouse			□м □г					urrent priysi	ciari, crieck	t box at right.		attach verification.	attach verificatio	Do	any of the depende	ents listed in this address?
Child			□м □ г									□ Yes □ No	□ Yes □ No	If ye	es, who and at what plain the circumstan	t address?
Child			□ м □ ғ									□ Yes □ No	□ Yes □ No		ny dependent's last	
Child			□ м □ ғ									□ Yes □ No	□ Yes □ No	fron	n yours, explain the	circumstances:
5 Other Inst	urance Inform	nation To be sur	e that y	ou receive	all the b	penefits to which	n you are									
If yes, please give	employed? □ Yes ve name, address, ar of spouse's employer	nd						any persoi covered by	ns listed of any oth	effective with on this enroll er health insu	ment	form be	tho is cove		this policy?	List names
	of your dependents c	urrently receiving Me se give name of recip		benefits					ase give	name and po			1)			
PARTA		PARTB EFFEC		DATE MEI	DICARE	CLAIM NUMB	_					(*	2)			
SELF Yes No		□ Yes □ No -						Policy Nur Policy Hol				(;	3)			
CHILD Yes No		□ Yes □ No -	-					Type of be ☐ Health		iption 🖵 De	ntal !	☐ Vision (4	1)			

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COMPLETE	THIS SECTION IF APPLYING FO	R COVERAGE UNDER THE	NEW JERSEY SM.	ALL EMPLOYER HEALTH BENEFITS	PROGRAM ONLY.	
Occupation:	Title:	Date of Emplo	yment:	Hours Worked Per Week:	Are you actively at work?	Yes N
If you are declining enrollment for yourself or you enrollment within 30 days after your other covera request enrollment within 30 days after the marria	ge ends. In addition, if you have a new	v dependent as a result of marriag				
Persons to be covered:	☐ Employee & Child(ren)	☐ Employee & Spouse	☐ Employee, S	pouse & Child(ren)		
Which coverage have you selected to be primary	in the event expenses are incurred as	a result of an automobile related i	njury? Auto _	Medical		
Are you replacing existing coverage? Yes	No If "Yes", give the name and	policy number of the replaced car	rier, the effective and	ermination dates, and the name(s) of the po	ersons covered by the policy	
Were you, or any dependent(s) to be covered, co Plan Coverage, you and any dependents to be co				Group Health Plan Coverage. Please note	that if you do not provide the Certifica	ite of Group Healtl
DECLARATION I hereby enroll for the group coverage to which I a				SEY SMALL EMPLOYER HEALTH BE	ENEFITS PROGRAM	
I represent that to the best of my knowledge and	belief, the statements and answers giv	en above are true and complete.	I understand that the	nformation shall form the basis upon which	I may be included for coverage under	the group plan.
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I qualify under a waiver of the active work requirement

- c) the Employer is hereby designated my representative for the purpose of receiving contributions and remitting them to AmeriHealth.
 - Ameril-Health does not pay benefits for charges, or provide services or supplies related to a preexisting condition for 180 days, measured from the enrollment date. I understand that a Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a person's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date. I also understand that New Jersey Law only permits the application of the preexisting conditions limitation under certain circumstances and that I or my dependents will only be subject to this limitation to the extent permitted by New Jersey Law.

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HN	Ю	POS	PPO	CMM	Rx	Vision	Dental		HMC	C	P	os	PF	,O
								\$10 \$20			\$10	\$20	\$10	\$20

For all plans, including	JUNE PORING PORI	P.O. Box 42555 Philadelphia, PA	19101	-2555							\$10	\$20	\$10	\$20	\$10 \$2	20
2 Subscri	ber/Member En	rollment or (Chan	ge - Empl	oyee Must	Compl	ete in F	ull								
☐ New Application ☐ New Hire ☐ Open Enrollme ☐ Life Event Cha Complete all informa and sign form.	Provide your Iden indicate the changinge appropriate section	nge tification Number be ge(s) you are making n(s) and sign at bot	g. Com	plete □ Last orm. □ Prim □ Rehi	ess Name ary Care Office	Change Add De If addin marriag	ent Members ependent g spouse, ir ge date/ Dependent	ndicate	🖵 29 r	BRA mos. mos.		nversion/	□ Tern □ Full- □ Dec	time to Pa eased, da n Enrollm	mployment art-time ate:/	<i>J</i>
3 Subscri	ber Information			ete this section in the to an existing	n its entirety, who	ether you ar	e a new app	olicant		3/	A Group/	Employ	er In	forma	tion	
Social Security Number	r Last Name		First N			ddle Initial	Sex ☐ M ☐ F		e of Birth th/day/year / /	Tr	our Group Adm nis form cannot Check if Natio	be proces	sed wit			
Street Address		C	City		State		Zip Code			Gro	oup Number	Group Nar	ne (Full L	egal Name	e of Company)	/
Telephone Number (include area code) H	ome: () —	Emple □ Act □ Re		Status Marit COBRA Statu		☐ Divorce ☐ Married		Health I	nsurance	Acc	count Number	Group Ado	ress			
	te this section f	or HMO or P	os o	Only						Em	ployer Signature	and Date				
Primary Care Office Na	ame If Current Phys	sician Check This Box 「	<u> </u>	Primary Care	Office Code Numbe	ar					Date of Hir		Date Co	overage/Ch	ange is Effect	ive
Primary Dental Office N 4 Depende	Name If Current Dent ent Information	ist Check This Box 🖵 - Please provide a	ll inform		I Office Code Numb	ered. 4				_	Payroll/Work Lo	cations	40			
Full Name Last Name	First Name	Middle Initial	Sex	Date of Birth Month/day/year	Social Security N	umber	mary Care Office Name Irrent physician		ary Care Office Number ox at right.	ce	Overage Student? Please attach	Disabled Please attach	Dep	endent Inforr	l any dependents mation Section, y e questions bel	you
Spouse			□м □ г				, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,		3		verification.	verificatio	n. Do seci	ion live at an	pendents listed in other address?	n this
Child			□м □ ғ							ᅵᅴ	□ Yes □ No	□ Yes □ No		s, who and a lain the circu	at what address? mstances:	
Child			м □ г							回	□ Yes □ No	□ Yes □ No	If ar	y dependent	's last name is di	lifferen
Child			□ м □ ғ								□ Yes □ No	□ Yes □ No	fron	yours, expla	ain the circumsta	nces:
5A Is your spous If yes, please	surance Inform e employed? Yes give name, address, and of spouse's employer	□ No				5C	entitled, you When you be any persons covered by a Yes □ No	ecome e listed or any othe	ffective with this enroll	n our men	r policy, will water torm be	f those cov	ered.	•	cy? List na	
Are you or ar Yes PART A		e give name of recip	oient.		RE CLAIM NUMI	I i BER I	f yes, please nsurance ca ns. Co. Nam	e give na rrier and ne	type of be	nefit	S. (2	2)				
SELF Yes ON SPOUSE Yes ON CHILD Yes ON	No [☐ Yes ☐ No - ☐ Yes ☐ No - ☐ Yes ☐ No -	- - -			F	Policy Number Policy Holder Type of benealth Delegates	r efits:			(3	3)				

Important: Please read the back of this form, then sign below.

COMPLETE T	HIS SECTION IF APPLYING FO	R COVERAGE UNDER THE N	NEW JERSEY SMALL	EMPLOYER HEALTH BENEFITS	PROGRAM ONLY.
Occupation:	Title:	Date of Employ	yment:	Hours Worked Per Week:	Are you actively at work? Yes N
	ends. In addition, if you have a new	dependent as a result of marriage			r dependents in this plan, provided that you request nroll yourself and your dependents, provided that you
Persons to be covered:	☐ Employee & Child(ren)	☐ Employee & Spouse	☐ Employee, Spous	se & Child(ren)	
Which coverage have you selected to be primary in	the event expenses are incurred as	a result of an automobile related in	njury? Auto	Medical	
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Plan Coverage, you and any dependents to be cover	ered, may be required to satisfy the pr	eexisting conditions limitation, if ap	oplicable.	up Health Plan Coverage. Please note t	that if you do not provide the Certificate of Group Health

DECLARATION AUTHORIZATION AND CONDITIONS OF ACCEPTANCE FOR THE NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM

I hereby enroll for the group coverage to which I am or may be entitled. I authorize deductions from my pay for my share of the cost, if any.

I represent that to the best of my knowledge and belief, the statements and answers given above are true and complete. I understand that the information shall form the basis upon which I may be included for coverage under the group plan.

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- I am either actively at work for full pay on a full-time basis on the date coverage is to take effect, or subject to applicable regulations,
 I qualify under a waiver of the active work requirement
- b) no person, except an officer of AmeriHealth has authority to: determine whether certificate/evidence of coverage shall be issued based on this Enrollment Form, waive or modify any of the provisions of the Enrollment Form, or any of the AmeriHealth Requirements; to bind AmeriHealth by any statement or promise pertaining to any certificate/evidence of coverage to be issued on the basis of this Enrollment Form; or accept any information or representation not contained in the written Enrollment Form.
- c) the Employer is hereby designated my representative for the purpose of receiving contributions and remitting them to AmeriHealth.
 - AmeritHealth does not pay benefits for charges, or provide services or supplies related to a preexisting condition for 180 days, measured from the enrollment date. I understand that a Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a person's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date. I also understand that New Jersey Law only permits the application of the preexisting conditions limitation under certain circumstances and that I or my dependents will only be subject to this limitation to the extent permitted by New Jersey Law.

I understand that by signing below when I file a claim, AmeriHealth may pay the health care benefits directly to the provider instead of to me.

I state that I am a resident of New Jersey and I live, reside or work within AmeriHealth's service area. I understand that if I omit or falsify any statement on this enrollment form, AmeriHealth can cancel my coverage as of the original effective date.

Any person who includes any false or misleading information on an application or enrollment form and change form for a health benefits plan is subject to criminal and civil penalties.

Note: A person who was covered under Creditable Coverage has a right to request a certificate from the prior plan or issuer to demonstrate that he or she was covered under Creditable Coverage. If necessary, AmeriHealth will assist the person in obtaining a certificate from the prior plan or issuer.

Conditions of Acceptance

On behalf of myself and the dependents listed on this Enrollment Form. I agree to or with the following:

- 1. Employee is applying for coverage for the employee, employee's spouse and any eligible unmarried children under nineteen (19) years of age, unmarried children who are mentally or physically incapacitated and who are chiefly dependent upon the employee or the employee's spouse for support and maintenance or are unmarried children between the ages of nineteen (19) and twenty-three (23) who are enrolled as full-time students at an accredited school.
- 2. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the Contract.
- 3. The Contract will determine the rights and responsibilities of members and will govern in the event it conflicts with any benefits comparison, summary or other description of the health benefits plan.
- 4. As a condition to receiving in-network benefits, employee understands and agrees that with the exception of emergency procedures as defined in the Contract all in-network services, in order to be covered by AmeriHealth, must be performed either by a participating primary care physician or by the participating specialist, hospital or other provider as authorized by prior written referral from the participating primary care physician. Out-of-network benefits are covered, as stated in the contract
- 5. Employee agrees to make payment directly to health care providers such copayments as are provided in the employer's health benefits plan.
- 6. Employer understands that this coverage will remain in effect regardless of the continued availability of a particular primary care physician.
- 7. Employee acknowledges that AmeriHealth's participating providers, including all participating primary care physicians, are independent contractors and are not agents or employees of AmeriHealth.

Authorization

- 1. I authorize the sources stated below to give to AmeriHealth, or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, advice, treatment or supplies for any physical or mental condition. Authorized sources are: any physician or medical professional; any hospital, clinic or other medical care institution; any carrier; any consumer reporting agency; any employer.
- 2. I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which AmeriHealth has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
- 3. I know that I have a right to receive a copy of this authorization if I request one.
- 4. I agree that a photocopy of this authorization is as valid as the original.

I understand that if I choose an HMO Product the provision of services to me and my dependents as Members of AmeriHealth is governed by the applicable Group Master Contract, which provides that: 1) except for emergencies, all medical or dental care must be initialed at the primary care office or primary dental office (as appropriate) we have selected; and 2) and my dependents authorize any person or organization providing services to furnish AmeriHealth with medical or dental records or other information concerning such services for purposes of AmeriHealth quality and utilization review. I understand that if I choose a Point of Service Product, I will be subject to applicable deductible, coinsurance and other copayments for all non-referred services, as specified in the contract. I further understand that I can change health plan coverage only at the time my employer and AmeriHealth specify.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any material false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.