AmeriHealth Insurance Company of New Jersey
AmeriHealth HMO, Inc.
8000 Midlantic Drive Suite 333
Mt. Laurel, NJ 08054

AmeriHealth NEW JERSEY

APPLICATION FOR A SMALL EMPLOYER HEALTH BENEFITS POLICY

Please Print or Type

AmeriHealth Insurance Company of New Jersey
AmeriHealth HMO, Inc.
Policy Number _____
(AmeriHealth use only)

[ ] New Policy [ ] Change in Policy [ ] Requested Effective Date _____

SECTION I: POLICYHOLDER INFORMATION

1. Policyholder (full legal name of Company): _____

2. Tax ID #: _____

3. Main Address: _____
   Street City State Zip

   Mailing Address: _____
   Street City State Zip

   Telephone: ( ) _____ Facsimile: ( ) _____

4. Name of Correspondent: _____

5. Type of Organization: [ ] Corporation [ ] Partnership [ ] Proprietorship [ ] Other (explain) _____

6. Nature of business: (specify) _____ SIC Code: _____

7. Number of eligible employees in your company: _____
   Refer to the New Jersey Small Employer Certification for the definition of an eligible employee.

8. Number of eligible employees to be insured: _____

9. Class or classes to be excluded: _____

10. Insurance Requested For: [ ] Employees Only [ ] Employees and Dependents
    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

11. Are you subject to the requirements of COBRA? [ ] Yes [ ] No

12. Is your employer subject to the requirements of Medicare as Secondary Payor Rules for eligibility
    due to age? [ ] Yes [ ] No due to disability? [ ] Yes [ ] No

13. Waiting period before employees become insured: (may not exceed 6 months)
    Present Employees _____ New or Rehired Employees _____

14. What percentage of the premium will the employer pay? _____

15. Deposit $_____ Premium Paid: [ ] Monthly [ ] Quarterly

Premium will be due as of the effective date. The premium for the first month of coverage must be attached.

Affiliates, subsidiaries or branches: (Must be included for purposes of participation)

Legal Name and Location	No. Eligible Employees in this Company	No. Eligible Employees to be Insured

SECTION II: SPECIFICATIONS FOR COVERAGE

HMO

Copayment: ☐ $15 ☐ $20 ☐ $30 ☐ $40

Coinsurance: ☐ $20/70% ☐ $30/60%

Plan: ☐ Basic ☐ Premium

Standard Drug: ☐ 50%/50%

Select Drug: ☐ $5/$25/$50 ☐ $10/$40/$60 ☐ $15/$35/$50
☐ $7/$35/$50 ☐ $15/$25/$35 ☐ $20/$40/$60

Deductible /Copayment Drug: ☐ $100/$15/$15 ☐ $100/$15/$25
☐ $200/$15/$15 ☐ $200/$15/$25
☐ $100/$15/$25/$35 ☐ $200/$15/$25/$35

☒ Drug Retail Dispensing/Copays: 90 Day/3 Copays
(For Deductible /Copayment Program, Deductible must be met first)

Split Copay HMO

☐ $15/$30 $0/Day ☐ $15/$30 $200/Day ☐ $20/$40 $0/Day
☐ $20/$40 $300/Day ☐ $30/$50 $0/Day ☐ $30/$50 $400/Day

HMO Plus

☐ $15/$30 $200/Day ☐ $20/$40 $300/Day ☐ $30/$50 $400/Day

Standard Drug: ☐ 50%/50%

Select Drug: ☐ $5/$25/$50 ☐ $10/$40/$60 ☐ $15/$35/$50
☐ $7/$35/$50 ☐ $15/$25/$35 ☐ $20/$40/$60

☒ Drug Retail Dispensing/Copays: 90 Day/3 Copays

Vision: ☐ $35 ☐ $100

PPO Deductible Copay

☐ Plan B ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $30
(80/60) Combined Deductible in/out-of-network

☐ Plan C ☐ $250 ☐ $500 ☐ 1,000 ☐ $2,500 ☐ $20 ☐ $30
(100/70) Out-of-network Deductible

☐ Plan D ☐ $250 ☐ $500 ☐ $1,000 ☐ $20
(100/80) Out-of-network Deductible

100% Hospitalization
☐ Yes
☐ No

Integrated Drug
☐ Yes
☐ No

Standard Drug: ☐ 50%/50%

Select Drug: ☐ $5/$25/$50* ☐ $10/$40/$60 * ☐ $15/$35/$50*
☐ $7/$35/$50* ☐ $15/$25/$35 ☐ $20/$40/$60*

Deductible/Copayment Drug: ☐ $100/$15/$15* ☐ $100/$15/$25*
☐ $200/$15/$15* ☐ $200/$15/$25*
☐ $100/$15/$25/$35* ☐ $200/$15/$25/$35*

* Only available with Plan B and Plan C medical options with an office visit copay of $20 or more and an Out-of-Network deductible of $500 or more

☒ Drug Retail Dispensing/Copays: 90 Day/3 Copays
(Except Integrated Drug; For Ded/Copay Program, Deductible must be met first)

Vision: ☐ $35 ☐ $100

POS

Copayment: ☐ $15 ☐ $20 ☐ $30 ☐ $40

Plan: ☐ Basic ☐ Premium

Option: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

Standard Drug: ☐ 50%/50%

Select Drug: ☐ $5/$25/$50 ☐ $10/$40/$60 ☐ $15/$35/$50
☐ $7/$35/$50 ☐ $15/$25/$35 ☐ $20/$40/$60

Deductible /Copayment Drug: ☐ $100/$15/$15 ☐ $100/$15/$25
☐ $200/$15/$15 ☐ $200/$15/$25
☐ $100/$15/$25/$35 ☐ $200/$15/$25/$35

☒ Drug Retail Dispensing/Copays: 90 Day/3 Copays
(For Deductible /Copayment Program, Deductible must be met first)

Split Copay POS

☐ $15/$30 $0/Day ☐ $15/$30 $200/Day ☐ $20/$40 $0/Day
☐ $20/$40 $300/Day ☐ $30/$50 $0/Day ☐ $30/$50 $400/Day

POS Plus

☐ $15/$30 $200/Day ☐ $20/$40 $300/Day ☐ $30/$50 $400/Day

Standard Drug: ☐ 50%/50%

Select Drug: ☐ $5/$25/$50 ☐ $10/$40/$60 ☐ $15/$35/$50
☐ $7/$35/$50 ☐ $15/$25/$35 ☐ $20/$40/$60

☒ Drug Retail Dispensing/Copays: 90 Day/3 Copays

Vision: ☐ $35 ☐ $100

Traditional Med (CMM)

Plan: ☐ A ☐ B ☐ C ☐ D ☐ E

Deductible: ☐ $150 (Plans A & E)
☐ $250 (Plans B,C or D)
☐ $500 (Plans B,C or D)
☐ $1,000 (Plans B,C or D)

Integrated Drug (Not available with A)

☐ Yes ☐ No

Standard Drug: ☐ $5/$10($0/$5 mail)

☒ Drug Retail Dispensing/Copays: 90 Day/3 Copays
(Except Integrated Drug)

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(s), give a description of the plan(s) and name of insurance carrier(s):

   _____

2. Name of present or prior group carrier: _____
   Effective date of prior coverage: _____
   Cancellation/Termination date: _____
   Is the coverage applied for in this application replacing other group insurance? [ ] Yes [ ] No
   If "Yes," give reason: _____
   Plan being replaced: [ ] A [ ] B [ ] C [ ] D [ ] E [ ] HMO [ ] HMO-POS [ ] Dual Contract POS
   [ ] Other _____

3. Has your firm been uninsured for 3 or more months prior to application? [ ] Yes [ ] No

4. What forms of insurance are now or were in force?
   [ ] Health Benefits [ ] Prescription Drugs
   (Attach copies of Booklet/Certificate and most recent Billing Statement)

5. Are extended benefits provided in case of termination of health benefits? [ ] Yes [ ] No
6. 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

Please provide the following information for each current/former employee or dependent on health continuations.

Name of Employee/Dependent	Date of Birth	Type of Continuation State/Federal Extended Benefits	Reason for Termination Disability/Other	Continuation Dates Start	Continuation Dates End

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

7. To the best of your knowledge:
7a. Are any employees or dependents presently incapacitated? [ ] Yes [ ] No
7b. 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.

SECTION IV: AGENT/PRODUCER INFORMATION

Agent/Broker

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. A full-time employee is one who regularly works at least 25 hours per week at his employer's place of business. 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.

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_____ 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.

AmeriHealth HMO, Inc. • AmeriHealth Insurance Company of New Jersey