AmeriHealth

AmeriHealth SEH Group Data Form

(For 2 to 50 Eligibles)

CID#	Region Code ☐ NJ ☐ NN

NAME OF GROUP			GRP # (NEW)	GRP # (PRESENT)
ADDRESS			EFFECTIVE DATE	TYPE OF INDUSTRY
CITY	STATE	ZIP	SIC CODE	REP CODE
GROUP LEADER NAME	TELEPHONE#			AFFILIATION CODE

☐ New Group ☐ Add Program ☐ Update Group Benefits

GENERAL INFORMATION

1. PROTECTION STARTS: ☒ Yes

If yes, describe (based on date of hire)

Waiting Period _____

2. EMPLOYER PARTICIPATION:

☐ None ☐ 100% ☐ Partial _____ %

☐ Other, Describe

_____

_____

3. CARRIER ELIMINATED CODE

☐ Yes ☐ No

If yes, name _____

Copy of Group Bill on file?

☐ Yes ☐ No

4. # ELIG. EMPLOYEES | # IN AMERIHEALTH HMO

OF WAIVERS | TOTAL ENROLLED

APPS COMPLETED | APPS TO FOLLOW

MO/ DAY/ YEAR

PRE-EXISTING CONDITIONS: ☐ Full Waiver
☐ 6 month Pre Ex applies (waiver may be at member level)
☐ 6 month Pre Ex applies waiver for initial enrollees

MIS INFORMATION

BROKER/CONSULTANT INVOLVEMENT

☐ None ☐ Broker ☐ Consultant

BROKER OF RECORD LETTER ON FILE

☐Yes ☐ No

NAME OF BROKER/CONSULTANT CODE

FIRM NAME CODE

ARE ANY EMPLOYEES COVERED BY ANOTHER CARRIER? ☐ Yes ☐ No

IF YES, CARRIER NAME CARRIER CODE

SEH PRODUCT OPTIONS

PPO
☐ Plan B (80/60)
☐ Plan C (100/70)
☐ Plan D (100/80)
☐ Other: _____

Deductible
☐ $500 ☐ $1000 ☐ $2500
☐ $250 ☐ $500 ☐ $1000 ☐ $2500
☐ $250 ☐ $500 ☐ $1000

Copay
☐ $30
☐ $5 ☐ $10 ☐ $20 ☐ $30
☐ $5 ☐ $10 ☐ $20

100% Hospitalization
☐ Yes
☐ No

CMM
☐ Plan A (80/20)
☐ Plan B (60/40)
☐ Plan C (70/30)
☐ Plan D (80/20)
☐ Plan E (90/10)
☐ Other: _____

Deductible
☐ $250
☐ $250 ☐ $500 ☐ $1000
☐ $250 ☐ $500 ☐ $1000
☐ $250 ☐ $500 ☐ $1000
☐ $150

Integrated Drug
☐ Yes
☐ No

SUPPLEMENTAL PROGRAMS

Standard Drug
☐ $5/$10
☐ $15 (PPO Only)
☐ $15/$25 (PPO Only)
☐ 50%/50% (PPO Only)

Select Drug (PPO Only)
☐ $5/$15/$25
☐ $5/$20/$35
☐ $10/$20/$35
☐ $15/$25/$35

Deductible/Copayment Drug (PPO Only)
☐ $100/$15/$15
☐ $100/$15/$25
☐ $200/$15/$15
☐ $200/$15/$25
☐ $100/$15/$25/$35
☐ $200/$15/$25/$35

Drug Retail Dispensing
☐ 90 Day/3 Copays or Coinsurance (For Deductible/Copayment Program, Deductible must be met first)
☐ 90 Day or 100 units whichever is greater/1 Copay (Standard Drug Only)

AH (Davis) Vision
☐ $35 ☐$100
Bi-annual benefit

Prior Coverage ☐ Active ☐ Cancelled

COMMENTS _____

Rep's Signature Date:

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AHSEHGRP 2/4/04