AmeriHealth

ENROLLMENT/CHANGE FORM

For all plans, including New Jersey Small Group Employer Benefits Program

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

1 Plan (please specify Fast Track or Standard)

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

HMO	POS	PPO	CMM	Rx	Vision	Dental

1B Fast Track (Circle co-pay)

HMO		POS		PPO	
$10	$20	$10	$20	$10	$20

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
- ❑ DentalOffice

❑ **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
- ❑ Other:_____

3 Subscriber Information

NOTE: Please complete this section in its entirety, whether you are a new applicant or are making a change to an existing contract.

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

Street Address	City	State	Zip Code

Telephone Number (include area code)	Employment Status	Marital Status	Previous Health Insurance
Home: ( ) – Work: ( ) –	❑ Active ❑ COBRA ❑ Retiree	❑ Single ❑ Divorced ❑ Separated ❑ Married ❑ Widowed	

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 (Full Legal Name of Company)
Account Number	Group Address

Employer Signature and Date

Date of Hire	Date Coverage/Change is Effective
___/___/___	___/___/___
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 Code Number
Primary Dental Office Name	If Current Dentist Check This Box ❑	Primary Dental Office Code Number

4 Dependent Information - Please provide all information for each person to be covered.

4A For HMO/POS Only

4B Verifications

Full Name Last Name	First Name	Middle Initial	Sex	Date of Birth Month/day/year	Social Security Number	Primary Care Office Name (If current physician, check box at right.)	Primary Care Office Number		Overage Student? Please attach verification.	Disabled? Please attach verification.
Spouse			❑ M ❑ F					❑		
Child			❑ M ❑ F					❑	❑ Yes ❑ No	❑ Yes ❑ No
Child			❑ M ❑ F					❑	❑ Yes ❑ No	❑ Yes ❑ No
Child			❑ M ❑ F					❑	❑ Yes ❑ No	❑ Yes ❑ No

4C

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

Do any of the dependents listed in this section live at another address?
❑ Yes ❑ No

If yes, who and at what address? Explain the circumstances:

If any dependent's last name is different from yours, explain the circumstances:

5 Other Insurance Information

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

5A Is your spouse employed? ❑ Yes ❑ No
If yes, please give name, address, and phone number of spouse's employer _____

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

	PART A	EFFECTIVE DATE	PART B	EFFECTIVE DATE	MEDICARE CLAIM NUMBER
SELF	❑ Yes ❑ No	- -	❑ Yes ❑ No	- -	
SPOUSE	❑ Yes ❑ No	- -	❑ Yes ❑ No	- -	
CHILD	❑ Yes ❑ No	- -	❑ Yes ❑ No	- -	

5C When you become effective with our 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 no. of insurance carrier and type of benefits.
Ins. Co. Name _____
Policy Number _____
Policy Holder _____
Type of benefits:
❑ Health ❑ Prescription ❑ Dental ❑ Vision

Who is covered by this policy? List names of those covered.
(1) _____
(2) _____
(3) _____
(4) _____

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

_____ Signature of Employee

_____ Date Signed

Copy 1: AmeriHealth