GROUP ENROLLMENT/CHANGE REQUEST

[Carrier Logo]	Group Information – to be completed by [Employer]:		
[Carrier Name]	Group Name:	[Group Number]:	[Class Code]:

A. Type of Activity – to be completed by [Employer]. *Refer to instructions [on back] before completing this form. Print clearly.*

	Activity – Check all that apply	Effective Date/ Date of Event	Date of Hire/Reason for Change
1. ADD	☐ Enrollment of a new [Enrollee/Subscriber] ☐ Add Spouse[/Civil Union Partner] [☐Civil Union Partner] ☐ Add Domestic Partner ☐ Add Dependent Child ☐ Add Over-Age Child as a Dependent Under 30*(and complete section A 4)*	_____/_____/_____ _____/_____/_____ [_____/_____/_____] _____/_____/_____ _____/_____/_____ _____/_____/_____	Date of Hire: _____/_____/_____ _____ [_____] _____ _____ _____
2. REMOVE	☐ [Employee] Withdrawal/Termination ☐ Remove Spouse[/Civil Union Partner] [☐Civil Union Partner] ☐ Remove Domestic Partner ☐ Remove Dependent Child ☐ Remove Over-Age Child as a Dependent Under 30	_____/_____/_____ _____/_____/_____ [_____/_____/_____] _____/_____/_____ _____/_____/_____ _____/_____/_____	_____ _____ [_____] _____ _____ _____
3. OTHER CHANGE	☐ Name Change ☐ Change Plan ☐ Other ☐ [Add/Change Office ID Numbers: Primary/OB/Gyn/ Dentist]	_____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____	_____ _____ _____ _____

4. COVERAGE CONTINUATION

☐ For Employee
- ☐ Total Disability*
- ☐ COBRA/NJSGC
  - Length of Continuation (in months):
  - ☐ 18 ☐ 29
  - Date of Loss of Coverage: ___/___/___
  - Qualifying Event #:_____**
  - Date of Qualifying Event: ___/___/___

[Billing: ☐ Group ☐ Home (Section B)]

**Attach proof of disability*

☐ For Spouse/Civil Union Partner*
- Length of Continuation (in months):
- ☐ 18 ☐ 36
- Date of Loss of Coverage: ___/___/___
- Qualifying Event #:_____**
- Date of Qualifying Event: ___/___/___

[Billing: ☐ Group ☐ Home (what address?)
☐ Section B *OR*
☐ Section [F]]

**Civil union partners are eligible to make an election pursuant to NJSGC, if applicable..*

☐ For Dependent or Over-age Child
- ☐ COBRA/NJSGC
  - Length of Continuation (in months):
  - ☐ 18 ☐ 36
  - Loss of Coverage: ___/___/___
  - Qualifying Event #:_____**
  - Date: ___/___/___
- ☐ Dependent Under 30
  - Qualifying Event #:_____**

[Billing: ☐ Group*** ☐ Home (what address?)
☐ Section B *OR*
☐ Section [G]]

***Qualifying event #s: see list in Instructions. [***Billing through the group for a Dependent Under 30 Continuation Election requires agreement by the employer at Section [L] .]*

B. [Employee] Information – to be completed by the [Employee]	Name (Last, First, MI):	SSN:

Home	Street/Apt:_____ Street/Apt:_____ City:_____ State:_____ Zip Code: _____	Birthdate (mm/dd/yyyy): ☐ Male ☐ Female Phone: (_____)_____ [Email: _____]
Work	[Employer] Name:_____ Address:_____ City:_____ State:_____ Zip Code: _____	Phone: (_____)_____ [Email: _____] Employment Date: _____/_____/_____ Hours worked per week:_____
Activity	☐ Add ☐ Remove ☐ Continuation ☐ Other Change *If a name change, indicate prior name:*	
	[Primary address: _____ zip+4] [NPI #:]	[Current Patient: ☐ Yes ☐ No]
	[Ob/Gyn address: _____ zip+4] [NPI #:]	[Current Patient: ☐ Yes ☐ No]
	[Dentist address: _____ zip+4] [NPI #:]	[Current Patient: ☐ Yes ☐ No]

Other Health Coverage? ☐ Yes ☐ No *If yes:* Payer Name: _____ Policy #: _____ Medicare ID#, if any:	[Other Rx Coverage? ☐ Yes ☐ No *If yes:* Payer Name: _____ Policy #: _____ Medicare ID#, if any:]
Previous Coverage? ☐ Yes ☐ No *If Yes:* Effective date: _____/_____/_____ Termination date: _____/_____/_____	Payer Name:_____ Policy #:_____ [*Submit a Certificate of Creditable Coverage*]

C. Plan Option – to be completed by the [Employee] *Check one [Plan Name] [and] [Copay] [and] [or] [Deductible] [and] [or] [Coverage Status]*

D. Other Individuals Covered – to be completed by the [Employee] *Identify individuals other than yourself for whom you are adding/changing/removing/continuing coverage. Attach additional pages if necessary, with your signature and dated. [Attach proof if full-time post-secondary student.] [Attach proof of disability.]*

1. Spouse; Domestic or Civil Union Partner	**2.Child**	**3. Child**	**4. Child**
☐Add ☐ Remove ☐Other ☐Continue Spouse ☐Continue CU Partner (NJSGC)	☐ Add ☐ Remove ☐ Other ☐ Continue	☐ Add ☐ Remove ☐Other ☐ Continue	☐ Add ☐ Remove ☐Other ☐ Continue
Name (last, first, MI) L:_____ F:_____ MI:	Name (last, first, MI) L:_____ F:_____ MI:	Name (last, first, MI) L:_____ F:_____ MI:	Name (last, first, MI) L:_____ F:_____ MI:
Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):

☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Social Security Number:	Social Security Number:	Social Security Number:	Social Security Number:
Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name: ______________________________ Policy #: ______________________ Medicare ID #:	Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name: ______________________________ Policy #: ______________________ Medicare ID #:	Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name: ______________________________ Policy #: ______________________ Medicare ID #:	Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name: ______________________________ Policy #: ______________________ Medicare ID #:
Previous Coverage: ☐ Yes ☐ No *If yes:* Effective:____/____/___ Termination: ___/___/___ Payer Name: ______________________________ Policy #: ______________________ [submit a copy of the Certificate of Creditable Coverage]	Previous Coverage: ☐ Yes ☐ No *If yes:* Effective:____/____/___ Termination: ___/___/___ Payer Name: ______________________________ Policy #: ______________________ [submit a copy of the Certificate of Creditable Coverage]	Previous Coverage: ☐ Yes ☐ No *If yes:* Effective:____/____/___ Termination: ___/___/___ Payer Name: ______________________________ Policy #: ______________________ [submit a copy of the Certificate of Creditable Coverage]	Previous Coverage: ☐ Yes ☐ No *If yes:* Effective:____/____/___ Termination: ___/___/___ Payer Name: ______________________________ Policy #: ______________________ [submit a copy of the Certificate of Creditable Coverage]
[Other Rx Coverage: ☐ Yes ☐ No *If yes:* Payer Name: ______________________________ Policy #: ______________________ Medicare ID #:]	[Other Rx Coverage: ☐ Yes ☐ No *If yes:* Payer Name: ______________________________ Policy #: ______________________ Medicare ID #:]	[Other Rx Coverage: ☐ Yes ☐ No *If yes:* Payer Name: ______________________________ Policy #: ______________________ Medicare ID #:]	[Other Rx Coverage: ☐ Yes ☐ No *If yes:* Payer Name: ______________________________ Policy #: ______________________ Medicare ID #:]
[Primary Care Provider: NPI#:__________________ Address:______________________ ______________________________ ____________zip+4____________ [Current Patient? ☐Yes ☐ No]]	[Primary Care Provider: NPI:____________________ Address:______________________ ______________________________ ____________zip+4____________ [Current Patient? ☐ Yes ☐ No]]	[Primary Care Provider: NPI#:__________________ Address:______________________ ______________________________ ____________zip+4____________ [Current Patient? ☐Yes ☐ No]]	[Primary Care Provider: NPI#:__________________ Address:______________________ ______________________________ ____________zip+4____________ [Current Patient? ☐Yes ☐ No]]

[Ob/Gyn Office NPI#:_____ Address:_____ _____ _____ zip+4 _____ [Current Patient? ☐Yes ☐ No ☐ NA]]	[Ob/Gyn Office NPI#:_____ Address:_____ _____ _____ zip+4 _____ [Current Patient? ☐ Yes ☐ No ☐ NA]]	[Ob/Gyn Office NPI#:_____ Address:_____ _____ _____ zip+4 _____ [Current Patient? ☐ Yes ☐ No ☐ NA]]	[Ob/Gyn Office NPI#:_____ Address:_____ _____ _____ zip+4 _____ [Current Patient? ☐Yes ☐No ☐ NA]]
[Dentist Office NPI#:_____ Address:_____ _____ _____ zip+4 _____ [Current Patient? ☐Yes ☐ No]]	[Dentist Office NPI#:_____ Address:_____ _____ _____ zip+4 _____ [Current Patient? ☐Yes ☐ No]]	[Dentist Office NPI#:_____ Address:_____ _____ _____ zip+4 _____ [Current Patient? ☐Yes ☐ No]]	[Dentist Office NPI#:_____ Address:_____ _____ _____ zip+4 _____ [Current Patient? ☐Yes ☐ No]]
Employed? ☐ Yes ☐ No *If yes, complete Section [F]1*	If last name is different from [Employee's], please explain: _____ _____	If last name is different from [Employee's], please explain: _____ _____	If last name is different from [Employee's], please explain: _____ _____
Home or billing address same as [Employee]? ☐ Yes ☐ No *If NO, complete Section [F]2*	Living with [Employee]? ☐ Yes ☐ No *If NO, complete Section [G]*	Living with [Employee]? ☐ Yes ☐ No *If NO, complete Section [G]*	Living with [Employee]? ☐ Yes ☐ No *If NO, complete Section [G]*

[**E. Preexisting Conditions** – to be completed by [Employee]. *Complete if you are a new enrollee except when enrolling in a Small Employer Group health benefits plan with more than 5 [employees]. Complete for all late enrollees. If you check one of the conditions in #1, or respond yes to any question in #2, give details on a separate sheet of paper. This separate sheet must be signed and dated by you.* This information may ONLY be used to determine if a condition is a pre-existing condition. You CANNOT be denied coverage under a health benefits plan on the basis of accurate responses to the following questions. Carriers may only use the information to expedite the processing of claims.]

[1. If you or any dependent to be covered has been diagnosed as having any of the following within the past [6] months, please place a check mark in the appropriate box:]

[☐ a. Alcoholism or Drug Abuse
☐ b. Arthritis
☐ c. Blood Disorder
☐ d. Back or Neck Disorder, Injury or Pain
☐ e. Cancer or Tumors
☐ f. Diabetes
☐ g. Gastro or Intestinal Disorder
☐ h. Heart Disorder/Condition /Chest Pain
☐ i. High Blood Pressure
☐ j. Kidney or Liver Disorder
☐ k. Lung or Respiratory Disorder
☐ l. Mental or Nervous Disorder
☐ m. Paralysis, Stroke or Epilepsy]

[2. During the past [6] months, have you or any dependent to be covered:]	[Yes	No]
[a. been examined or treated by a physician or other health care provider for any condition, illness or injury, other than as stated above?	[☐	☐
b. been advised to have treatment or surgery or testing that has not been done?	☐	☐
c. been admitted to a hospital or other health care facility as an inpatient?	☐	☐
d. taken prescribed medication?]	☐	☐]

[F.] Additional Spouse/Civil Union Partner/Domestic Partner Information – to be completed by [Employee] If *not applicable, please mark as "NA."*	1. Employer Name:_____ Employer Address:_____ City, State, Zip Code:_____ Employer Phone: ( )
2a. Street/Apt:_____ Street/Apt:_____ City, State, Zip Code:_____	2b. Please explain why the address is different: _____ _____

[G.] Additional Child Information – to be completed by [Employee]. *Provide information below about children listed in Section D,* **if** *they have a different address from the employee. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.*

Name(s):_____	Name(s):_____
Street/Apt:_____	Street/Apt:_____
Street/Apt:_____	Street/Apt:_____
City, State, Zip Code: _____	City, State, Zip Code:_____
Reason:_____	Reason:_____

[H.] Additional Information for Dependent Under 30 Continuation Elections – Provide information below about children listed in Section D for whom a Dependent Under 30 continuation election is being made.	This Continuation Election is being made: ☐ During an Open Enrollment period [for the group] [for the Over-Age Child based on his/her age-out anniversary] ☐ Within 30 days prior to the attainment of the limiting age (when the Dependent will become an Over-Age Child) ☐ Within 30 days after the Over-Age Child has established eligibility for a Chapter 375 Continuation Election [☐ Special May 12, 2006 through May 11, 2007 enrollment period]
[I.] Race/Ethnicity – to be completed by the [Employee], at his/her option. *NOTE: your response is appreciated but NOT required!*	*Choose a category that most closely describes you:* ☐ American Indian or Alaskan Native ☐ Black, not of Hispanic origin ☐ Hispanic ☐ Asian or Pacific Islander ☐ White, not of Hispanic origin
[J.] [Employee] Signature	I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I authorize deductions from my earnings for any contributions required from me. Signature: _____ Date: _____
[K.] Over-Age Child's Signature	I represent that all the information supplied in this application regarding the [Dependent Under 30] Continuation Election is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. [I hereby agree to make contributions required from me for the Dependent Under 30 Continuation Election.] Signature: _____ Date: _____
[L.] [Employer] Verification	The requested activity is believed eligible and is approved by the [Employer]. [In addition, the [Employer] consents to payroll deduction for Dependent Under 30 Continuation Election: ☐ Yes ☐ No] Employer Representative: _____ Date: _____ Representative's Title: _____

INSTRUCTIONS

[Employers] – You must complete the [Employer] Group Information and sections A and [L] in order for this application to be processed.

[Employees] – You must complete sections B through [J] and submit the signature of each Over-Age Child for which a Dependent Under 30 Continuation Election is made in accordance with Section [K] in order for this application to be processed.

- Please PRINT except when a signature is requested.
- If a dependent is disabled and you want to continue his or her coverage beyond [age 18][the limiting age], you do not have to make a COBRA/NJSGC or Dependent Under 30 election. Instead, select "Other" in Section A3, and attach proof of disability.
- For provider addresses, include the zip code plus the four digit extension (11 digits)
- [If a dependent is a full-time post-secondary student, you must attach a current course schedule or a letter from the school or its authorized representative confirming full-time student status.]
- You can obtain the providers' correct names and addresses from the appropriate provider directory. You may also obtain each provider's NPI number [from the provider directory] [or] [and] [at: URL] [or] [and] [by contacting the provider directly.] Providers with multiple office locations and individual providers who belong to more than one practice or provider entity may have more than one NPI number. You should confirm the correct NPI number for the specific provider and office location where you will be seen by contacting that office directly.

Qualifying Events

COBRA and NJSGC
C1. Termination of job or reduction in hours
C2. Employee enrollment in Medicare (COBRA only)
C3. Divorce (COBRA/NJSGC); civil union dissolution (NJSGC)
C4. Death of employee
C5. Loss of dependent child status under the plan
C6. Disability (occurring subsequent to another qualifying event)
Dependent Under 30
D1. Loss of dependent status and otherwise eligible
D2. Reestablish eligibility: residency
D3. Reestablish eligibility: nonresident full-time student
D4. Reestablish eligibility: change in marital status
D5. Reestablish eligibility: change in parental status
D6. Reestablish eligibility: termination of other coverage

CONDITIONS OF ENROLLMENT -- [APPLICANT] ACKNOWLEDGEMENTS AND AGREEMENTS

On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer reporting agency, and any employer to give [Carrier Name], or any consumer reporting agency acting on behalf of [Carrier Name], information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that [Carrier Name] has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one.
4. I agree [Carrier] will provide coverage in accordance with the terms of the contract for the group [plan] [policy].
5. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the group [plan] [policy] if premiums are not paid timely. I authorize my Employer to withhold payments from my wages as contribution to the premium, as appropriate.

Carrier instructions

(not to be included in the Enrollment/Change Request form when printed by the carrier)

1. Carrier should insert its logo and name where indicated, or leave the table blank, or blacked-out.
2. Carrier must replace bracketed text "carrier name" with carrier's full name throughout the document.
3. If the carrier refers to the "Employer" using another term such as "Planholder" or "Contractholder" or some similar term, replace the term "Employer" with such other term throughout the document.
4. If the carrier refers to "Group Number/Class Code" using some other term such as "Policy Number," "Control Number" or some similar term, replace the term "Group Number/Class Code" with such other term.
5. Replace "on back" with appropriate directions if the instructions are not provided on the reverse side.
6. If the carrier refers to the "Enrollee/Subscriber" using another term such as "Member" or "Applicant" or some similar term, replace the term "Enrollee/Subscriber" with such other term throughout the document.

7. In Section A1 and 2, the carrier may choose to put Civil Union Partner on the same line as Spouse, or insert new lines for Civil Union Partner separately.
8. In Section A, omit "Add/Change Office ID Numbers" options if carrier does not offer such options.
9. In Section A, the continuation billing options should be omitted if the carrier does not offer such options. In addition, the phrase "***_Billing through the group for a Dependent Under 30 Continuation Election requires agreement by the employer at Section [L]_" if the carrier does not offer the Integrated continuation coverage option.
10. In Section B, references to the employee's e-mail address should be omitted if the contact option is not offered.
11. At Section B and D, references to primary, ob/gyn and dentist selections should be omitted is selections are not an option or a requirement. If a carrier does not assign numbers for each office location, then carriers may indicate that LOC refers to the office location in the selection information, and request that enrollees identify a name for the office location. However, carriers should not request complete office address locations.
12. At Section B and D, reference to current patient information should be omitted if the carrier does not require it.
13. At Section C, insert carrier plan options and deductibles, coinsurance or copayment options, and provide directions for employee/enrollee selections of options as appropriate.
14. At Section D1, the carrier may elect not to reference Domestic Partner if an employer does not permit coverage of Domestic Partners.
15. At Section D1, the carrier may indicate that continuation is an option for "Spouse only" for groups subject ONLY to COBRA.
16. At Section D, requests for information about other prescription drug coverage are optional.
17. At Section D, if the carrier does not require proof of full-time student status provided with the enrollment form and/or proof of disability, omit the directions to attach proof.
18. If Section [E] is omitted, renumber Sections F through L accordingly.
19. At Section [F], carriers may omit Domestic Partners if the employer does not allow coverage for domestic partners.
20. At Section [H], use the phrase "for the Over-Age Child based on his/her age-out anniversary" for defined small employer groups.
21. At Section [H], carriers may remove the option "Special May 12, 2006 through May 11, 2007 enrollment period" as of May 12, 2007.
22. At Section [L], omit "In addition, the [Employer] consents to payroll deduction for Dependent Under 30 Continuation Election: ☐ Yes ☐ No" if the carrier does not offer the Integrated continuation coverage option.
23. At Instructions, if you require selection of health care providers, insert appropriate information on how the to obtain correct NPI numbers. Note that indicating information is available only through a website is not appropriate.
24. At the Footnote, if a carrier does not utilize an "Internal Carrier Form Number," the carrier may omit the reference.

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