

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]. <i>Refer to instructions [on back] before completing this form. Print clearly.</i>			
Activity – Check all that apply		Effective Date/ Date of Event	Date of Hire/Reason for Change
1. ADD	<input type="checkbox"/> Enrollment of a new [Enrollee/Subscriber] <input type="checkbox"/> Add Spouse[/Civil Union Partner] <input type="checkbox"/> Civil Union Partner <input type="checkbox"/> Add Domestic Partner <input type="checkbox"/> Add Dependent Child <input type="checkbox"/> Add Over-Age Child as a Dependent Under 31 <i>(and complete section A 4)</i>	____/____/____ ____/____/____ [____/____/____] ____/____/____ ____/____/____ ____/____/____	Date of Hire: ____/____/____ _____ [_____ _____ _____
2. REMOVE	<input type="checkbox"/> [Employee] Withdrawal/Termination <input type="checkbox"/> Remove Spouse[/Civil Union Partner] <input type="checkbox"/> Civil Union Partner <input type="checkbox"/> Remove Domestic Partner <input type="checkbox"/> Remove Dependent Child <input type="checkbox"/> Remove Over-Age Child as a Dependent Under 31	____/____/____ ____/____/____ [____/____/____] ____/____/____ ____/____/____ ____/____/____	_____ _____ [_____ _____ _____
3. OTHER CHANGE	<input type="checkbox"/> Name Change <input type="checkbox"/> Change Plan <input type="checkbox"/> Other <input type="checkbox"/> [Add/Change Office ID Numbers: Primary/OB/Gyn/ Dentist]	____/____/____ ____/____/____ ____/____/____ ____/____/____	_____ _____ _____ _____
4. COVERAGE CONTINUATION	<input type="checkbox"/> For Employee <input type="checkbox"/> Total Disability* <input type="checkbox"/> COBRA/NJSGC Length of Continuation (in months): <input type="checkbox"/> 18 <input type="checkbox"/> 29 Date of Loss of Coverage: ____/____/____ Qualifying Event #: _____** Date of Qualifying Event: ____/____/____ [Billing: <input type="checkbox"/> Group <input type="checkbox"/> Home (Section B)] *Attach proof of disability	<input type="checkbox"/> For Spouse/Civil Union Partner* Length of Continuation (in months): <input type="checkbox"/> 18 <input type="checkbox"/> 36 Date of Loss of Coverage: ____/____/____ Qualifying Event #: _____** Date of Qualifying Event: ____/____/____ [Billing: <input type="checkbox"/> Group <input type="checkbox"/> Home (what address?) <input type="checkbox"/> Section B OR <input type="checkbox"/> Section [F]] *Civil union partners are eligible to make an election pursuant to NJSGC, if applicable..	<input type="checkbox"/> For Dependent or Over-age Child <input type="checkbox"/> COBRA/NJSGC Length of Continuation (in months): <input type="checkbox"/> 18 <input type="checkbox"/> 36 Loss of Coverage: ____/____/____ Qualifying Event #: _____** Date: ____/____/____ <input type="checkbox"/> Dependent Under 31 Qualifying Event #: _____** [Billing: <input type="checkbox"/> Group*** <input type="checkbox"/> Home (what address?) <input type="checkbox"/> Section B OR <input type="checkbox"/> Section [G]]
Qualifying event #s: see list in Instructions. [*Billing through the group for a Dependent Under 31 Continuation Election requires agreement by the employer at Section [L] .]			

B. [Employee] Information – to be completed by the [Employee]	Name (Last, First, MI): _____	SSN: _____
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Home	Street/Apt: _____ Street/Apt: _____ City: _____ State: _____ Zip Code: _____	Birthdate (mm/dd/yyyy): _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
		Phone: (____) _____ [Email: _____]	

Work	[Employer] Name: _____ Address: _____ City: _____ State: _____ Zip Code: _____	Phone: (____) _____ [Email: _____]	
		Employment Date: ____/____/____ Hours worked per week: _____	

Activity	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continuation <input type="checkbox"/> Other Change <i>If a name change, indicate prior name:</i>		
	[Primary Loc #:] _____ address: _____ zip+4 _____]	[NPI #:] _____	[Current Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No]
	[Ob/Gyn Loc #:] _____ address: _____ zip+4 _____]	[NPI #:] _____	[Current Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No]
	[Dentist Loc #:] _____ address: _____ zip+4 _____]	[NPI #:] _____	[Current Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No]

Other Health Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i> Payer Name: _____ Policy #: _____ Medicare ID#, if any: _____	[Other Rx Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i> Payer Name: _____ Policy #: _____ Medicare ID#, if any: _____]
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Previous Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes:</i> Effective date: ____/____/____ Termination date: ____/____/____	Payer Name: _____ Policy #: _____ [Submit a Certificate of Creditable Coverage]
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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 of disability.]*

1. Spouse; Domestic or Civil Union Partner	2. Child	3. Child	4. Child
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Other <input type="checkbox"/> Continue Spouse <input type="checkbox"/> Continue CU Partner (NJSGC)	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Other <input type="checkbox"/> Continue	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Other <input type="checkbox"/> Continue	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Other <input type="checkbox"/> 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): _____

<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security Number: _____	Social Security Number: _____	Social Security Number: _____	Social Security Number: _____
Other Health Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i> Payer Name: _____	Other Health Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i> Payer Name: _____	Other Health Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i> Payer Name: _____	Other Health Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i> Payer Name: _____
Policy #: _____ Medicare ID #: _____	Policy #: _____ Medicare ID #: _____	Policy #: _____ Medicare ID #: _____	Policy #: _____ Medicare ID #: _____
Previous Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i> Effective: ____/____/____ Termination: ____/____/____ Payer Name: _____	Previous Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i> Effective: ____/____/____ Termination: ____/____/____ Payer Name: _____	Previous Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i> Effective: ____/____/____ Termination: ____/____/____ Payer Name: _____	Previous Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i> Effective: ____/____/____ Termination: ____/____/____ Payer Name: _____
Policy #: _____ [submit a copy of the Certificate of Creditable Coverage]	Policy #: _____ [submit a copy of the Certificate of Creditable Coverage]	Policy #: _____ [submit a copy of the Certificate of Creditable Coverage]	Policy #: _____ [submit a copy of the Certificate of Creditable Coverage]
[Other Rx Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i> Payer Name: _____	[Other Rx Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i> Payer Name: _____	[Other Rx Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i> Payer Name: _____	[Other Rx Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i> Payer Name: _____
Policy #: _____ Medicare ID #:]	Policy #: _____ Medicare ID #:]	Policy #: _____ Medicare ID #:]	Policy #: _____ Medicare ID #:]
[Primary Care Provider: NPI#: _____	[Primary Care Provider: NPI#: _____	[Primary Care Provider: NPI#: _____	[Primary Care Provider: NPI#: _____
Address: _____	Address: _____	Address: _____	Address: _____
_____ zip+4	_____ zip+4	_____ zip+4	_____ zip+4
[Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No]]	[Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No]]	[Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No]]	[Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No]]

[F.] Additional Spouse/Civil Union Partner/Domestic Partner Information – to be completed by [Employee] If <i>not applicable</i> , 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]. <i>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.</i>		
Name(s): _____ Street/Apt: _____ Street/Apt: _____ City, State, Zip Code: _____ Reason: _____	Name(s): _____ Street/Apt: _____ Street/Apt: _____ City, State, Zip Code: _____ Reason: _____	
[H.] Race/Ethnicity – to be completed by the [Employee], at his/her option. <i>NOTE: your response is appreciated but NOT required!</i>	<i>Choose a category that most closely describes you:</i> <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Black, not of Hispanic origin <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> White, not of Hispanic origin	
[I.] [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: _____	
[J.] Over-Age Child’s Signature	I represent that all the information supplied in this application regarding the [Dependent Under 31] 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 31 Continuation Election.] Signature: _____ Date: _____	
[K.] [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 31 Continuation Election: <input type="checkbox"/> Yes <input type="checkbox"/> 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 31 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 26, you do not have to make a COBRA/NJSGC or Dependent Under 31 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)
- 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 31
- 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 31 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 if 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 disability, omit the directions to attach proof.
18. If Section [E] is omitted, renumber Sections F through K accordingly.
19. At Section [F], carriers may omit Domestic Partners if the employer does not allow coverage for domestic partners.
20. At Section [K], omit “In addition, the [Employer] consents to payroll deduction for Dependent Under 31 Continuation Election: Yes No” if the carrier does not offer the Integrated continuation coverage option.
21. At Instructions, if you require selection of health care providers, insert appropriate information on how to obtain correct NPI numbers. Note that indicating information is available only through a website is not appropriate.
22. At the Footnote, if a carrier does not utilize an “Internal Carrier Form Number,” the carrier may omit the reference.