APPENDIX EXHIBIT 1A

[Carrier Logo][1] **Enrollment/Change Request**

[Carrier Name][2]

[Employer][3] Group Information – To be completed by [Employer]

Group Name _____ [Group Number _____ Class Code][4] _____

A. Type of Activity – To Be Completed by [Employer]. Refer to instructions [on back][5] before completing this form. Print clearly.

1. Enrollment □ New [Enrollee/Subscriber][6] Effective Date ___/___/___ Date of Hire ___/___/___

2. Change – Check all that apply

	Date of Event	Reason
□ Add Spouse	___/___/___	_____
□ Add Dependent Child	___/___/___	_____
□ Name Change	___/___/___	_____
□ Change Plan	___/___/___	_____
□ Other	___/___/___	_____

□ [Add/Change Office ID Numbers: Primary / Ob/Gyn / Dentist][7]

3. Remove or Terminate – Check all that apply

	Effective Date	Reason
□ Remove Spouse*	___/___/___	_____
□ Remove Dependent Child*	___/___/___	_____
□ [Employee] Withdrawal/Termination	___/___/___	

NOTE: [Employee] must be enrolled for spouse/dependent(s) to have coverage.

* Please complete *Add/Change/Remove* and *Name* columns in Section D.

4. Continuation of Coverage, i.e. COBRA, State, total disability. Not all options are available or applicable. Contact [Employer] for available options.

Coverage for: □ [Employee] □ Dependents

Length of Continuation: □ 12 mos □ 18 mos □ 29 mos □ 36 mos □ total disability*

Date of Loss of Coverage: ___/___/___ Date of Qualifying Event: ___/___/___

[Billing: □ Home □ Group][8]

* Attach proof of total disability

B. [Employee] Information – Complete Sections [B-H][9]

Last name, First name, M.I. _____

Social Security Number_____ Home Telephone _____

Home address_____ Apt. No ___ City, State_____ Zip Code _____

[Employer] Name _____ Work Telephone _____

Work address_____ City, State_____ Zip Code _____

Date of Employment: _____Hours worked per week: _____

C. Plan Option – Your selection must be offered by [your Employer]
Check one: [Indicate Plan Names/Copays/Deductibles][10]

D. Individuals Covered – List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. [Attach proof if full-time college student. Attach proof of disability][11]

	(A)dd (C)hange (R)emove	Last Name,. First Name, M.I	Sex M F	Birthdate MM DD YYYY	Social Security Number	Other Health Coverage	[Other Rx Drug Coverage][14]	[Primary Office ID Number][12]	[Current Patient][13]	[Ob/Gyn Office ID Number] (if applicable)[15]	[Current Patient]	[Dentist Office ID Number] (if applicable)[16]	[Current Patient]	Previous Coverage Check if yes
[Employee]				___/____/____										
Spouse				___/____/____										
Child				___/____/____										
Child				___/____/____										
Child				___/____/____										
Child				___/____/____										
Child				___/____/____										

[**E. Pre-Existing Conditions Statement]** [17]
[Note: 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 can only use the information to expedite the processing of claims.
Yes No 1. During the past [6][18] months, have you or any dependent to be covered had or been diagnosed as having any of the following? If "Yes," check appropriate box(es) below.
☐ ☐
☐ 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 or Condition or 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

Yes No 2. During the past [6] months, have you or any dependent to be covered:
☐ ☐ 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?
Please give details for "Yes" answers to any part of Questions 1 or 2 on a separate sheet of paper. This separate sheet should be signed and dated.]

[F]. Other / Previous Insurance
Is your spouse employed? ☐Yes ☐No If "Yes" give name and address of your spouse's employer

____

If "Yes" to Other Health Coverage (Section D), give name & policy number of insurance carrier, HMO, or other source**.** If enrolled in Medicare Parts A and/or B identify the coverage and provide the Medicare ID #.

____

If “Yes” to Other Rx Drug Coverage (Section D), give name & policy number of insurance carrier, HMO, or other source.

_____

If “Yes” to Previous Coverage, identify name(s) of persons, give effective date and date coverage terminated, name of previous carrier and plan number.

_____

[G]. Dependent Information

Does any dependent listed in Section D live at a different address than the [Employee]? □Yes □No If “Yes” who and at what address?

_____

Explain the circumstances.

_____

If any dependent’s last name differs from yours, explain the circumstances.

_____

[H] [Employee] Signature *If you have questions concerning the benefits and services provided by or excluded under this [Agreement][19] contact a [Member Services][20] representative at [phone number][21] before signing this form.*

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the [reverse] side of the employee] copy of this enrollment/change request. I authorize deductions from my earnings for any required contributions.

[[Employee]Signature – Required X _____ Date ___/___/___ E-Mail Address _____

[I] [Employer Verification – To be Completed by [Employer]

[Employer]Signature – Required X _____ Title _____ Date ___/___/___

[[Employee] copy may be used as a temporary ID card for 30 days from the effective date if authorized by [employer]. Coverage must be verified with [Carrier name] prior to visiting a specialist or admission to a hospital.][22]

[NJ-HINT]
[Internal Carrier Form Number][23]

Instructions

[Employer]

- Complete the [Employer] Group information [in the upper right corner] of the form.
- Section A – Type of Activity: Check boxes indicating reason(s) for submitting application.
- Complete Section [I] – [Employer] Verification [in the lower right corner] of the form.
  - [Employer] must complete this section for all new enrollments, coverage changes and terminations.
  - [Employer] must sign and date the Enrollment/Change Request in order for it to be processed.

[Employee] – Complete Sections [B-H]

Section B – [Employee] Information:

- Complete all information in order for your application to be processed.

Section C – Plan Option:

- [Check one Plan Option box, indicate Plan Option Name (where applicable) and check one Copay and/or Individual Deductible Amount (if applicable).]
- Select only an option offered by your [employer].

Section D – Individuals Covered:

- Add/Change/Remove – Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependents, if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
- [If a dependent is a full-time college student, you must attach a current course schedule or a letter from the school confirming full-time student status (12 or more credits). If dependent is disabled and being continued beyond the limiting age, attach proof of disability]
- If you or your dependent(s) have other Health [or Rx drug] coverage, check off the "Yes" box(es) and complete Section [F] – Other/Previous Insurance.
- [From the appropriate provider directory, locate the [6-digit] office ID number for the primary care physician, ob/gyn (if applicable) and/or dentist (if applicable). Indicate office ID number selection(s) on the form.]
- [If you are a current patient, please check the "Current Patient" box.]

Section [E] – Pre-Existing Conditions Statement:

- Complete this section for all new enrollments. Exceptions: For Small Employer Group coverage, this section must be completed only by persons enrolling in group coverage in a group of 2 – 5 [employees] and by late entrants.]

Section [F] Other / Previous Insurance

- Complete this section for all new enrollments or coverage changes. Coverage includes group coverage, governmental coverage, a church plan or Medicare.

Section [G] – Dependent Information

- Complete this section for all new enrollments or coverage changes

Section [H] – [Employee] Signature:

- Complete this section for all new enrollments, coverage changes and terminations.
- [Employee] must sign and date the Enrollment/Change Request Form in order for it to be processed.

Section [I] – [Employer] Verification:

- [Employer] must complete this section for all new enrollments, coverage changes and terminations.
- [Employer] must sign and date the Enrollment/Change Request Form in order for it to be processed.

Conditions of Enrollment

[Applicant] Acknowledgement and Agreements

On behalf of myself and the dependents listed [on the reverse side] I agree to or with the following:

1. a) I authorize the sources stated below to give to [Carrier Name], or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition. Authorized sources are any physician or medical professional; any hospital, clinic or other medical care institution; any carrier; any consumer reporting agency; any employer.
   b) I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which [carrier] has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
   c) I know that I have a right to receive a copy of the authorization if I request one.
   d) I agree that a photocopy of this authorization is as valid as the original.
2. I acknowledge by enrolling in a [Carrier Name] [plan or group policy] coverage is provided by [Carrier Name] in accordance with the contract.
3. Enrollment of myself and of the listed dependents into the plan is effective on acceptance by [Carrier Name].
4. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. My employer is hereby authorized to withhold payments from my wages, as appropriate.

Misrepresentation

5. Any person who includes any false or misleading information on an Enrollment/Change Request Form for a health benefits plan is subject to criminal and civil penalties.

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[1] Replace bracketed text with carrier's logo, or omit.
[2] 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] Omit one or more "Add/Change Office ID Numbers" options if carrier does not offer such options.
[8] The continuation billing options should be omitted if the carrier does not offer such options.
[9] Re-letter sections F – H accordingly if [Section E Pre-Existing Conditions Statement] is being omitted.
[10] Insert carrier plan options and deductibles, coinsurance or copayment options.
[11] If the carrier does not want the proof of full-time student status provided with the enrollment form and/or proof of disability, omit the directions to attach proof.

[12] Omit “Primary Office ID Number” section if the plan does not require the selection of a Primary Care Physician.
[13] Omit “Current Patient” section if the carrier does not require.
[14] Omit “Rx Drug” section and corresponding question in Section F if carrier does not require.
[15] Omit “Ob/Gyn Office ID Number” section if the plan does not require the selection of an Ob/Gyn Physician.
[16] Omit “Dentist Office ID Number” section if the plan does not require the selection of a Dentist.
[17] The text “and pre-existing conditions statement” should be omitted if the carrier does not elect to include the pre-existing conditions statement text as part of the standard enrollment form. Re-letter succeeding sections**.**
[18] Carrier’s pre-existing conditions period. For plans other than small employer plans, insert the pre-existing conditions periods that are contained in non-small employer plans. For small employer plans, the period is six months.
[19] If the carrier refers to the “Agreement” using another term such as “Plan,” “Contract,” “Policy’” or some similar term, replace the term “Agreement” with such other term throughout the document.
[20] If the carrier refers to “Member Services” using another term such as “Claim Office” or “Customer Service” or some similar term, replace the term “Member Services” with such other term.
[21] Insert carrier’s phone number.
[22] Carrier should insert the procedure to be followed to allow the applicant to secure coverage before the actual ID card is issued.
[23] Available for carriers that use an internal number in addition to the identifying form number.