Affiliated Physicians & Employers Health Plan

A NJ Self-Insured MEWA

Benefit Enrollment Form

for New and Terminated Employees (Members)

Administered by QUALCARE INC
30 Knightsbridge Road
Piscataway, New Jersey 08854
Toll Free: (888) 606-5152
Fax #: (855) 888-1231
mewaenrollment@qualcareinc.com

1: Type of Enrollment (Select one option)

❑ **New Enrollee**

Effective Date: _____ / _____ / _____

Select Coverage Type:

❑ Single ❑ Parent/Child(ren)
❑ Family ❑ Employee/Spouse
❑ Age 26-31 Dependent Election

❑ **COBRA Election** *Check this box if your current coverage is COBRA or State Continuation and please enter the date your continuation coverage first became effective:*

_____ / _____ / _____

❑ Check If not actively at work when this coverage becomes effective due to Disability, LOA, FMLA, Military Service or other: _____

❑ **Change in Coverage**

Effective Date: _____ / _____ / _____

Select New Coverage Type:

❑ Single ❑ Parent/Child(ren)
❑ Family ❑ Employee/Spouse

Reason for Change:

❑ Marriage ❑ Birth/Adoption
❑ Loss of Coverage ❑ Death
❑ Employment Status Change
❑ Other _____

❑ **Termination**

Effective Date
Of Termination: _____ / _____ / _____

Reason for termination:

❑ Termination of Employment
❑ No Longer Meets Eligibility
❑ Employment Status Change
❑ Death ❑ Divorce
❑ Other_____

Note: Coverage remains in effect until the end of the month in which notification is received.

(Only fill out Sections 1, 2 & 3, then date and sign the application)

2: Employer and Plan Selection Information

Employer's Account #:
(Provided by your employer)

Affiliation_____
Affiliation #_____

Medical Plan Selection:
(Confirm with employer which Plans are offered, ex. Plan A)

Benefit Option(s) Selection: **Dental**
(Confirm with employer which Benefits are offered, if any.)

Delta: ❑ PREMIER ❑ BASE **Guardian**: ❑ PPO ❑ DHMO

If electing DHMO provide Dentists PCD# _____

Rx Option Selection: (Confirm with employer which Rx options are offered, ex. Rx1) _____

Employer Name: _____

Employer Address: _____
Number & Street City State Zip

3: Employee Demographic Information

Employee Name: _____ _____ _____ _____-_____-_____
Last First MI **REQUIRED Social Security #**

Employee Address: _____
Number & Street (Apartment or Suite) City State Zip

Phone: (_____) _____ Date of Birth: _____ /_____ / _____ Date of Hire: _____ /_____/ _____

E-Mail Address: _____

Employee Status: ❑Full-Time ❑Part-Time Gender: ❑Female ❑ Male PCP Name_____ Weekly Hours Worked:_____
(Primary Care Physician Required for Plan M,N,X, & Y only)

4: Dependent Information - List only those dependents to be added or removed from coverage

❑ **Add** ❑ **Remove** the following dependent(s) to my coverage:

	Name	Date of Birth	Gender	REQUIRED Social Security #	Primary Care Physician (PCP) NAME (Required for Plan M,N,X, & Y only)
Spouse:	_____	_____/ _____ / _____	_____	_____ - _____ - _____	_____
	If Domestic Partner ❑check here. If Civil Union Partner ❑check here				
Child:	_____	_____/_____ / _____	_____	_____ - _____ - _____	_____
Child:	_____	_____/_____ / _____	_____	_____ - _____ - _____	_____
Child:	_____	_____/_____ / _____	_____	_____ - _____ - _____	_____
Child:	_____	____ /_____ / _____	_____	_____ - _____ - _____	_____
Child:	_____	____ / _____ / _____	_____	_____ - _____ - _____	_____

Please list additional dependents on a separate sheet of paper.

Waiver of Dependent Coverage (if none listed above), for dependents eligible under this Plan: *I realize that I can include my dependent(s) on my contract at this time but have chosen to exclude them. I understand that hereafter I may apply for dependent coverage only during an open enrollment period for my Plan or if a qualifying event occurs as defined in the Plan's Summary Plan Description.*

5: Summary of Benefits Coverage (SBC)

The Patient Protection and Affordable Care Act has established many new requirements and standards for group health plans, including the requirement to create and distribute a uniform Summary of Benefits and Coverage (SBC). The purpose of the SBC is to provide standard information and uniform language across the health benefits business to allow consumers to easily compare options and select health plans. Members can access SBC's by visiting **http://apehp.com/forms-documents/**. A hard copy of the SBC can also be provided upon request, please call the Plan at **(888) 670-8135** for a copy or if you have any questions about the SBCs. For more information regarding this healthcare reform provision, please visit **www.healthcare.gov**.

6: Proof of Coverage (Attach to this form)

The Plan reserves the right to request payroll information from you or your employer at any time to ensure that you meet or continue to meet the eligibility requirements of a full-time employee working 24 hours or more. The Plan also reserves the right to request a copy of the following documentation at any time for each eligible dependent: *Spouse- Marriage Certificate or Proof of Domestic Partnership or Civil Union Certificate (if applicable) / Handicapped or Disabled Proof of incapacity verification/*
Dependent child(ren) - Birth Certificate, Adoption Papers and/or Legal documentation from the court / Any additional information to verify coverage

7: Other Insurance / Coordination of Benefits Information

Are you covered under any other group health plan? YES ❑ NO ❑

Are any of your dependents covered by any other group health plan? YES ❑ NO ❑

If yes, complete details of other coverage must be noted in this Section. Otherwise, if you answered NO, please skip to section 7 of this form.

Part A: Divorce/Legally Separated. Please complete this part if you are divorced or legally separated, and you are applying for dependent coverage under this health plan. Otherwise, continue to Part B.

Date of Divorce/Separation _____

Name of Other Biological Parent _____ Date of Birth _____

*If divorced or legally separated **:*

- ❑ Divorce decree states other parent, _____, must provide health benefits.
- ❑ Divorce decree states joint custody with shared responsibility for medical expenses.
- ❑ Divorce decree does not specify parent responsible for medical expenses.
- ❑ Other, please explain _____

With what parent does the child(ren) reside? _____

***A copy of the section of the court decree pertaining to health coverage would be helpful to support your response.*

Part B: Other Coverage - Non Medicare. Please complete this section if you or any of your dependents are covered under any other group health plan.

Type of coverage: _____ Coverage Effective date: _____

Name of Policy holder: _____ Name of other Benefit Payer: _____

Address of other Benefit Payer: _____

List all eligible persons for whom you are applying for coverage under this Plan, who are covered by another plan:

❑ Yourself ❑ Your Spouse ❑ Your Child (ren): List Names _____

Name and Address of Spouse's Employer: _____

Part C: Medicare Coverage

Person eligible for Medicare _____

Medicare #: _____ Effective Date of Part A: _____ Effective Date of Part B: _____

Reason for Medicare Coverage: ❑ Age 65 or older ❑ Disability ❑ ESRD,Date Dialysis Treatment Began: _____ / _____ / _____

8: Application & Authorization

I hereby authorize any physician, hospital, insurer, or other organization or person having any records, data, or information concerning health history or medical insurance/coverage for myself or my eligible family members to furnish such records, data, or information as may be requested by the Plan, or its duly authorized representative. A photocopy of this authorization shall be considered as effective and valid as the original.

I declare that I have read this application in full and that all statements contained in this entire form about me and my dependents are true and correct to the best of my knowledge and that no material information has been withheld or omitted. I understand any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

I hereby apply for coverage on behalf of myself and eligible dependents listed on this form.

I hereby accept responsibility for payment of any portion of the Employee Contribution, if applicable, which I am required to pay, as well as any deductibles, copayments and coinsurance applicable under my Plan. Failure to remit payment will result in the immediate termination of coverage for myself and covered dependents. I further acknowledge that coverage shall become effective only if approved by the Plan Sponsor/Plan Administrator and only for services which are rendered on or after the effective date of coverage.

By providing my e-mail address, I hereby accept electronic delivery of all plan documents to my e-mail address. Plan documents include but are not limited to Health Care Quality Act, HIPAA Privacy Notice, Medicare Part D Notices, Summary Annual Report, Summary of Benefits and Coverage, Summary Plan Description, and Women's Health and Cancer Rights Act. Occasionally, in addition to electronic communications you may also receive a paper copy document. I understand that I can request a paper copy, free of charge, at any time by calling the plan. I can withdraw from the electronic delivery process at any time in the future by calling the plan. I can opt out of the electronic delivery process at this time by checking the box here: ❑

Date_____ **Employee Signature:** _____

9: To be completed by Employer

I am either the employer or a representative authorized to execute this form.

Employer Representative Signature: _____ **Proof of Coverage Satisfied (Check box)** : ❑