

## ENROLLMENT/CHANGE REQUEST SMALL EMPLOYER

### Group Information - To Be Completed by Employer

|            |              |                 |
|------------|--------------|-----------------|
| Group Name | Group Number | Subgroup Number |
|------------|--------------|-----------------|

### A. Type of Activity - To Be Completed by Employer. Refer to instructions on back before completing this form.

| <b>1. Enrollment</b><br><input type="checkbox"/> New Subscriber<br><br>Effective Date<br>____/____/____<br><br>Date of Hire<br>____/____/____   | <b>2. Change - Check all that apply:</b> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 35%;"></th> <th style="width: 15%;">Date of Event</th> <th style="width: 50%;">Reason</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Add Spouse/Domestic Partner</td> <td>____/____/____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Add Dependent Child</td> <td>____/____/____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Name Change</td> <td>____/____/____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Change Plan</td> <td>____/____/____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Other</td> <td>____/____/____</td> <td>_____</td> </tr> <tr> <td colspan="3"><input type="checkbox"/> Add/Change Office ID Numbers: Primary Care Physician</td> </tr> </tbody> </table> |               | Date of Event | Reason  | <input type="checkbox"/> Add Spouse/Domestic Partner | ____/____/____ | _____  | <input type="checkbox"/> Add Dependent Child | ____/____/____ | _____  | <input type="checkbox"/> Name Change | ____/____/____ | _____   | <input type="checkbox"/> Change Plan | ____/____/____ | _____ | <input type="checkbox"/> Other | ____/____/____ | _____ | <input type="checkbox"/> Add/Change Office ID Numbers: Primary Care Physician |  |  |
|---|---|---------------|---------------|---|--|----------------|--|--|----------------|--|--------------------------------------|----------------|---|--------------------------------------|----------------|-------|--------------------------------|----------------|-------|---|--|--|
|   | Date of Event   | Reason        |               |   |  |                |  |  |                |  |                                      |                |   |                                      |                |       |                                |                |       |   |  |  |
| <input type="checkbox"/> Add Spouse/Domestic Partner  | ____/____/____  | _____         |               |   |  |                |  |  |                |  |                                      |                |   |                                      |                |       |                                |                |       |   |  |  |
| <input type="checkbox"/> Add Dependent Child  | ____/____/____  | _____         |               |   |  |                |  |  |                |  |                                      |                |   |                                      |                |       |                                |                |       |   |  |  |
| <input type="checkbox"/> Name Change  | ____/____/____  | _____         |               |   |  |                |  |  |                |  |                                      |                |   |                                      |                |       |                                |                |       |   |  |  |
| <input type="checkbox"/> Change Plan  | ____/____/____  | _____         |               |   |  |                |  |  |                |  |                                      |                |   |                                      |                |       |                                |                |       |   |  |  |
| <input type="checkbox"/> Other  | ____/____/____  | _____         |               |   |  |                |  |  |                |  |                                      |                |   |                                      |                |       |                                |                |       |   |  |  |
| <input type="checkbox"/> Add/Change Office ID Numbers: Primary Care Physician   |   |               |               |   |  |                |  |  |                |  |                                      |                |   |                                      |                |       |                                |                |       |   |  |  |
| <b>3. Remove or Terminate</b><br><i>Check all that apply:</i> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 35%;"></th> <th style="width: 15%;">Date of Event</th> <th style="width: 50%;">Reason</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Remove Spouse/Domestic Partner</td> <td>____/____/____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Remove Dependent Child*</td> <td>____/____/____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Employee Withdrawal/Termination</td> <td>____/____/____</td> <td>_____</td> </tr> </tbody> </table> <p><b>NOTE:</b> Employee must be enrolled for spouse/dependent(s) to have coverage.<br/>*Please complete Add/Change/Remove and Name columns in Section D.</p> |   | Date of Event | Reason        | <input type="checkbox"/> Remove Spouse/Domestic Partner | ____/____/____                                       | _____          | <input type="checkbox"/> Remove Dependent Child* | ____/____/____                               | _____          | <input type="checkbox"/> Employee Withdrawal/Termination | ____/____/____                       | _____          | <b>4. Continuation of Coverage, i.e., COBRA, State, Total Disability</b><br><i>Not all options are available. Contact Employer for available options.</i><br><br>Coverage For: <input type="checkbox"/> Employee <input type="checkbox"/> Dependents<br><br>Length of Continuation: <input type="checkbox"/> 12 mos <input type="checkbox"/> 18 mos<br><input type="checkbox"/> 29 mos <input type="checkbox"/> 36 mos<br><br><input type="checkbox"/> Total Disability*<br><br>Date of Loss of Coverage: ____/____/____<br><br>Date of Qualifying Event: ____/____/____<br>*Attach proof of total disability |                                      |                |       |                                |                |       |   |  |  |
|   | Date of Event   | Reason        |               |   |  |                |  |  |                |  |                                      |                |   |                                      |                |       |                                |                |       |   |  |  |
| <input type="checkbox"/> Remove Spouse/Domestic Partner   | ____/____/____  | _____         |               |   |  |                |  |  |                |  |                                      |                |   |                                      |                |       |                                |                |       |   |  |  |
| <input type="checkbox"/> Remove Dependent Child*  | ____/____/____  | _____         |               |   |  |                |  |  |                |  |                                      |                |   |                                      |                |       |                                |                |       |   |  |  |
| <input type="checkbox"/> Employee Withdrawal/Termination  | ____/____/____  | _____         |               |   |  |                |  |  |                |  |                                      |                |   |                                      |                |       |                                |                |       |   |  |  |

### B. Employee Information - Complete Sections B - H

|  |                             |                |
|--|-----------------------------|----------------|
| Social Security Number   | Last Name, First Name, M.I. | Home Telephone |
| Home Address   | Apt.      City, State       | ZIP Code       |
| Employer Name  |                             | Work Telephone |
| Work Address   | City, State                 | ZIP Code       |
| Date of employment ____/____/____      Hours worked per week _____ |                             |                |



## Instructions

### Employer

- Complete the Employer Group information in along the top 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 and indicate the Plan Option Name (where applicable) and check one co-pay (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.
- 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 limiting age, attach proof of disability.
- If you or your dependent(s) have other health 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 primary care physicians. Indicate the 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 and 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

### Employee 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 either WellChoice Insurance of New Jersey, Inc. or WellChoice HMO of New Jersey, 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 either WellChoice Insurance of New Jersey, Inc. or WellChoice HMO of New Jersey 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 I have the 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 either WellChoice Insurance of New Jersey, Inc. or WellChoice HMO of New Jersey policy coverage is provided by either WellChoice Insurance of New Jersey, Inc. or WellChoice HMO of New Jersey in accordance with the contract.
3. Enrollment of myself and of the listed dependents into the plan is effective on acceptance by WellChoice Insurance of New Jersey, Inc. or by WellChoice HMO of New Jersey.
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.

# WELLCHOICE™

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 WellChoice Insurance of New Jersey, Inc. or WellChoice HMO of New Jersey prior to visiting a specialist or admission to a hospital.

Services and products provided by WellChoice Insurance of New Jersey, Inc. or WellChoice HMO of New Jersey.

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