

ENROLLMENT/CHANGE REQUEST LARGE EMPLOYER

Group Information - To Be Completed by Employer

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

1. Enrollment <input type="checkbox"/> New Subscriber Effective Date ____/____/____ Date of Hire ____/____/____	2. Change - Check all that apply: <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			3. Remove or Terminate <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>NOTE: Employee must be enrolled for spouse/dependent(s) to have coverage. *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	____/____/____	_____
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4. Continuation of Coverage, i.e., COBRA, State, Total Disability <i>Not all options are available. Contact Employer for available options.</i> Coverage For: <input type="checkbox"/> Employee <input type="checkbox"/> Dependents Length of Continuation: <input type="checkbox"/> 12 mos <input type="checkbox"/> 18 mos <input type="checkbox"/> 29 mos <input type="checkbox"/> 36 mos <input type="checkbox"/> Total Disability* Date of Loss of Coverage: ____/____/____ Date of Qualifying Event: ____/____/____ *Attach proof of total disability																																			

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 _____		

C. Plan Option - Your selection must be offered by your employer.

<p>Check one</p> <p><input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Spouse (or Domestic Partner)</p> <p><input type="checkbox"/> Employee & Child(ren) <input type="checkbox"/> Employee, Spouse (or Domestic Partner) & Child(ren)</p>	<p>Check one (and co-pay or coinsurance as applicable)</p> <p><input type="checkbox"/> HMO <input type="checkbox"/> ACCESS HMO</p> <p>Home/Office Visit Co-pay <input type="checkbox"/> \$5 <input type="checkbox"/> \$10 <input type="checkbox"/> \$15 <input type="checkbox"/> \$20 <input type="checkbox"/> \$30 <input type="checkbox"/> \$40 <input type="checkbox"/> \$50</p> <p><input type="checkbox"/> PPO</p> <p>Home/Office Visit Co-pay <input type="checkbox"/> \$5 <input type="checkbox"/> \$10 <input type="checkbox"/> \$12 <input type="checkbox"/> \$15 <input type="checkbox"/> \$20</p> <p>Out of Network Coinsurance <input type="checkbox"/> 80%/20% <input type="checkbox"/> 70%/30%</p>
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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.

(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	Primary Care Office ID Number	Current Patient	Previous Coverage
Employee		<input type="checkbox"/> <input type="checkbox"/>	___/___/___		Check if Yes <input type="checkbox"/>		Check if Yes <input type="checkbox"/>	Check if Yes <input type="checkbox"/>
Spouse		<input type="checkbox"/> <input type="checkbox"/>	___/___/___		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Domestic Partner		<input type="checkbox"/> <input type="checkbox"/>	___/___/___		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Child		<input type="checkbox"/> <input type="checkbox"/>	___/___/___		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Child		<input type="checkbox"/> <input type="checkbox"/>	___/___/___		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Child		<input type="checkbox"/> <input type="checkbox"/>	___/___/___		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

E. Other/Previous Insurance

Is your spouse employed? Yes No If "Yes" give name and address of your spouse's (or domestic partner's) employer.

<p>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 #.</p>	<p>If "Yes" to Previous Coverage, identify name(s) of persons, give effective date and date coverage terminated, name of previous carrier and plan number.</p>
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F. Dependent Information

Does any dependent listed in Section D live at a different address from the Applicant? Yes No If "Yes," who and at what address?

<p>Explain the circumstances.</p>	<p>If any dependents' last name differs from yours, explain the circumstances.</p>
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G. Employee Signature

If you have any questions concerning the benefits and services provided by or excluded under this contract, contact Member Services at 1-888-476-6986 before signing this form.

<p>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.</p>	<p>Employee Signature - Required</p> <p style="text-align: center;">X</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;">Date</td> <td style="width:50%;">E-Mail Address</td> </tr> <tr> <td> </td> <td> </td> </tr> </table>	Date	E-Mail Address		
Date	E-Mail Address				

H. Employer Verification - To Be Completed by Employer

<p>Employer Signature - Required</p> <p style="text-align: center;">X</p>	<p>Title</p> <p style="text-align: center;">_____</p> <p>Date</p> <p style="text-align: center;">___/___/___</p>
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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 H – 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 E – 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 – 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 F – Dependent Information

- Complete this section for all new enrollments or coverage changes.

Section G – 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 H – 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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