



GROUP BENEFIT APPLICATION

WellChoice HMO of New Jersey

PLEASE PRINT OR TYPE New policy Change in policy
Sales Rep. _____ Code: _____ Effective Date: ___/___/___

SECTION I: POLICYHOLDER INFORMATION

- Company name (full legal name of company): _____
- Tax Identification Number: _____
- Location address: _____
Billing address: _____ Street City State Zip County
Telephone: () _____ Street City Fax: () _____ State Zip County
- Name of correspondent: _____ Title: _____
- Type of organization: Corporation Partnership Proprietorship Other: _____
- Nature of business: (specify) _____ SIC Code: _____
- Number of employees in your company: _____
- Number of eligible employees to be insured: _____
- Number of COBRA Participants: _____
- Class or classes to be excluded: _____
- Insurance requested for: Employees Only Employees and Dependents Retirees (No. _____)
- Are you subject to the requirements of COBRA?: Yes No
- Waiting period before employees become insured:
 Date of hire ___ Days ___ Months 1st of month following _____ Other _____
- Dependent Coverage (Full-time student)? 19-23 19-25
- Date dependent coverage to be terminated? Birthday End of Calendar Year
- Premium paid: Monthly Quarterly
- Deductible Credit: Yes No

Affiliates, subsidiaries or branches (must be included for purposes of participation)

Legal name & location	Number of employees in this company	Number of employees to be insured

SECTION II: PRODUCT SELECTION

HOME/OFFICE CO-PAYMENTS

HMO \$5 \$10 \$15 \$20 \$30

HOSPITAL PER ADMISSION CO-PAYMENT OPTIONS (HMO ONLY)

\$0/\$0 \$100/\$250 \$250/\$625 \$500/\$1,250 *only available with \$20 or \$30 home/office co-payments
 \$500/\$1,000* \$1,000/\$2,000* \$1,500/\$3,000* \$2,500/\$5,000*

PRESCRIPTION DRUGS HMO ONLY

NO Rx Benefit Oral Contraceptives: Yes No Deductible: \$0 \$100 \$150

Card/Mail: \$5/\$15/\$25 \$10/\$20/\$30 \$10/\$25/\$50

OPTIONS

Mental Health: Outpatient Days: 20 40 60

Inpatient Days: 30 45 90

Chiropractic: None 20 Days 30 Days

Skilled Nursing: 60 Days 120 Days 365 Days

RATES

Rating Structure: 2 Tier 3 Tier 4 Tier
 Employee Family EE/Child EE/Spouse

HMO

Group Contribution: _____ % Employee Only _____ % Employee & Dependent

Additional benefit riders and deductible riders may be selected by the group upon 60 days notice to WellChoice, and will be applicable for a minimum period of one year. Rider cancellation will be permitted only at renewal. WellChoice will advise the group of, and the group will be liable for, any adjustment in premium relating to addition or cancellation of riders.

This agreement may be terminated by the group or by WellChoice giving 60 days prior written notice. In the event of termination by the group, the group will be required to pay charges to a date not less than 60 days subsequent to the receipt of the written notification by WellChoice. WellChoice may terminate this agreement on 30 days prior written notice to the group if the group fails to meet underwriting regulations.

If WellChoice HMO of New Jersey/WellChoice Insurance of New Jersey, Inc. issues a contract, the group agrees to:

- Make payroll deductions, if employee contributions are required, remit to WellChoice the charges payable in accordance with the terms of such contracts.
- Submit payment promptly, not to be received after the expiration of the grace period. (Failure to pay promptly could result in the termination of the group's coverage).
- Promptly provide WellChoice with any information WellChoice deems necessary for it to properly administer the coverage.
- Allow WellChoice to audit and/or make copies of any records which relate to the administration of this coverage. And promptly provide WellChoice with any information WellChoice deems necessary to properly administer the coverage as well as verify representations made by the group in this application.
- Ensure only eligible members of the organization are enrolled.
- Ensure compliance with TEFRA/DEGRA/COBRA/OBRA legislation as it relates to any active employee or dependent of an active employee for whom the group's benefits are primary.
- Ensure prompt conversion of Medicare-eligible retirees and actively employed members, and their dependents, not covered by TEFRA/DEFRA/COBRA/OBRA to Medicare related coverage.
- Ensure employees are provided with all relevant information about this group's program and that they have been advised of the importance of selecting a primary care physician (HMO only).
- Ensure all additions and deletions to WellChoice's list of covered members are reported promptly. Failure to report a deletion promptly could result in the group being responsible for premiums and claims incurred subsequent to the member's deletion.

It is understood that:

- If an acceptable Notice of Election Form is received for the group member prior to the group's established eligibility date, coverage will begin on the date of eligibility.
- If an acceptable Notice Of Election Form is received for the group member subsequent to the group's established eligibility date, coverage will begin on the date the Notice of Election Form is received and accepted by WellChoice.
- If the group has selected date of hire for eligibility, the Notice of Election Form for its members must be received no later than 30 days following the date of hire to be effective on the date of hire. If the enrollment form is received later than 30 days following the date of hire, coverage will be effective on the date the enrollment form is received and accepted by WellChoice.
- If any employee or dependent of an employee fails to select a primary care physician (PCP), WellChoice will select a PCP for the member. The member will have an opportunity to change that selection (HMO only).

INSURANCE FRAUD STATEMENT

Statement and answers provided by members of the group in their Notices of Election should be true and are representations made to induce the issuance of the member's coverage. Any misrepresentation of the facts which are material to the Notice of Election may result in the cancellation or rescission of the member's coverage at WellChoice HMO of New Jersey/WellChoice Insurance of New Jersey option. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Dated on / / at _____

Print Name of Officer, Partner or Proprietor

Signature of Officer, Partner or Proprietor

Witness to Signature

Note: If there are any modifications to the statements and answers given in this application (i.e. crossed out, whited-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.