[EXHIBIT G]

APPLICATION FOR INDIVIDUAL HEALTH BENEFITS PLAN FOR INDIVIDUALS AND FAMILIES

Eligibility Requirements

1. Eligibility requirements are determined under the Individual Health Coverage Reform Act of 1992, P.L. 1992, c.161.
2. You must be a New Jersey resident.
3. You and any family members you wish to cover must not be eligible to be covered under:
   (a) a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan; or
   (b) Medicare.
   (See item 5 below.)
4. You and any family members you wish to cover are not eligible for a standard individual health benefits plan if covered by another individual health benefits plan unless the other plan is being replaced by the plan being applied for with this application.
5. If the requested effective date is not completed, your effective date shall be no later than the first of the month following the month in which the completed application was dated and premium payment is received by us or our duly authorized agent. However, with respect to applications submitted during the October Open Enrollment Period by persons who are eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan, or persons who wish to replace their current health benefit plan with a more comprehensive individual health benefits plan, the effective date of your coverage shall be January 1 of the following calendar year. Current coverage should not be terminated until new coverage is in effect.

INDIVIDUAL APPLICATION INSTRUCTIONS

BEFORE COMPLETING THIS APPLICATION BE SURE TO FAMILIARIZE YOURSELF WITH THE BENEFIT OPTIONS AVAILABLE. [NOTE: [CARRIER'S] PARTICIPATING PROVIDERS, INCLUDING ALL [PARTICIPATING] [NETWORK] PRIMARY CARE PHYSICIANS, ARE INDEPENDENT CONTRACTORS AND ARE NOT AGENTS OR EMPLOYEES OF [CARRIER].]

COMPLETE ALL SECTIONS IF YOU ARE:
1. [Applying] [Enrolling] as a new [insured] [enrolled] [subscriber] [member].
2. Changing dependent coverage.

COMPLETE SECTIONS 1, 2, 3, [AND] [5] AND [6] IF YOU ARE TERMINATING YOUR COVERAGE.

Section 1--Print your full name along with the name(s) of your spouse and dependent children you wish to cover, if any. Provide date of birth, sex, and social security number for each individual listed. Your social security number is for our use. The New Jersey Individual Health Coverage Program Board will not collect or use your social security number. If a dependent is a full-time college student, you **must** attach a current course schedule or tuition receipt. If a dependent is beyond age 19 or 23, as applicable, but is mentally or physically handicapped or developmentally disabled, unmarried and chiefly dependent upon the applicant or applicant's spouse for support and maintenance, a physician's statement as to the dependent's physical or mental incapacity must be provided. The add/remove blocks should be checked **only** if you wish to add or remove a dependent from the plan.

Section 2--Complete all information.

Section 3--Check box(es) indicating options for coverage, type of contract, [payment plan] and reason(s) for submitting form (i.e., new enrollment, coverage change, name change, withdrawal).

Section 4--This information is required. Please complete all information.

[Section 5--For applicants only] From the appropriate [directory] [brochure] [ ] choose [the location number for] a Primary Care Physician [or Health Center] [and/or Gynecologist if applicable,] [for yourself and each member of your family] [required for all members]. [If you choose a Health Center, you must choose a Primary Care Physician who services that Health Center.] [Indicate whether you are choosing [carrier's] Statewide Physician Network or Health Center.] Check the change box only if you are changing providers.

Section [5/6]--Applicant **must sign** this section and date this form or it will not be processed.

CONDITIONS OF ACCEPTANCE

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

1. Coverage of applicant and of the listed dependents shall depend on acceptance by [carrier] after a review of the application [and receipt of payment].

2. Applicant is applying for individual coverage for the applicant, applicant's spouse and any eligible unmarried children under nineteen (19) years of age, unmarried children who are mentally or physically incapacitated or developmentally disabled, who are chiefly dependent upon the applicant or the applicant's spouse for support and maintenance, or are unmarried children between the ages of nineteen (19) and twenty-three (23) who are full-time students at an accredited educational institution.

3. Coverage and benefits are contingent on timely payment of premiums. Coverage may be terminated as provided in the Individual [Contract] [Policy].

4. The Individual [Contract] [Policy] will determine the rights and responsibilities of [insured(s)] [enrollee(s)] [subscriber(s)] [member(s)] and will govern in the event it conflicts with any benefits comparison, summary or other description of the health benefits plan.

5. [As a condition to benefits, applicant understands and agrees that (with the exception of a medical emergency as defined in the Individual [Contract] [Policy] all services, in order to be covered by [Carrier], must be performed either by a Primary Care Physician or by the specialist, hospital or other provider as authorized by prior written referral from the Primary Care Physician [or Care Manager].]

6. [[If applicable,] Applicant agrees to make payment directly to health care providers, such copayments as are provided for in the Individual [Contract] [Policy].]

7. [Applicant understands that this coverage will remain in effect regardless of the continued availability of a particular [Health Center], Primary Care Physician or other health care provider.]

8. [Applicant acknowledges that [Carrier's] participating providers, including all participating primary care physicians, are independent contractors and are not agents or employees of [Carrier].]

Please print in ink all information requested on this application.

1. Eligible Persons to be Enrolled. (Note: Dependent children may be covered under an adult-child(ren) or family contract only while unmarried and until [they attain] age 19, or 23 if full-time students. Unmarried, handicapped dependent children can continue beyond the age limits above as long as they remain incapacitated and unmarried.*

This section must be completed in its entirety.			BIRTHDATE			SEX	
LAST NAME	FIRST NAME	MI	MO	DAY	YR	M or F	Social Security Number
Applicant 1. o Add o Remove							__/__/__-__/__-__/__/__/
Spouse 2. o Add o Remove							__/__/__-__/__-__/__/__/
Child 3. o Add o Remove							__/__/__-__/__-__/__/__/
Child 4. o Add o Remove							__/__/__-__/__-__/__/__/
Child 5. o Add o Remove							__/__/__-__/__-__/__/__/

*Attach sheet to list additional children. [Attach proof if full-time student. Totally disabled children will be covered regardless of age. Attach proof of disability.]

DEPENDENT INFORMATION

Do any of the dependents listed in #1 live at another address? o Yes o No

If yes, who and at what address?

_____

Explain the circumstances.

_____

If any dependent's last name is different from yours, explain the circumstances.

_____

2. PRIMARY RESIDENCE (Note: You must be a Resident, which is defined as follows: a person :
   - whose primary residence is in New Jersey and who is present in New Jersey for at least six months of the Calendar Year; or
   - in the case of a person who has moved to New Jersey less than six months before applying for coverage, who intends to be present in New Jersey for at least six months of the Calendar Year.

Street _____ Apt._____ City _____ State _____ Zip _____

[Do you live, reside or work in the [Carrier's] service area? o Yes o No]

TELEPHONE NUMBER

Home ( ) - Work ( ) - Best place to call during day: o Home o Work

Are you a resident of the State of New Jersey? o Yes o No

Do you maintain a residence in any other state? o Yes o No

If "Yes", (a) Name of state _____
(b) How much time do you spend there each year? _____

[[If you or any of your dependents are covered under an existing health benefits plan, or if you or any of your dependents had coverage which terminated within the past 31 days, please provide the following information for each person who has or had such coverage.

Name(s) of Person(s): _____

Name of Carrier: _____

Policy Number: _____

Type of Coverage: Check all that apply.

_____Group _____Individual

_____Indemnity _____HMO _____PPO _____Point of Service

_____Other (Specify)_____

Plan Information: Deductible Amount: _____

Coinsurance: _____

Copayment: _____

Initial Effective Date: _____ Termination Date:_____

If one or more of the persons are or were covered under a separate plan, please use this section to provide information concerning the coverage for those persons.

Name(s) of Person(s): _____

Name of Carrier _____

Policy Number: _____

Type of Coverage: Check all that apply.

_____Group _____Individual

_____Indemnity _____HMO _____PPO _____Point of Service

_____Other (Specify)_____

Plan Information: Deductible Amount: _____

Coinsurance: _____

Copayment: _____

Initial Effective Date: _____ Termination Date:_____]]

COVERAGE (Please mark Coverage, Type of Contract and Type of Activity)

PLEASE ENROLL ME (AND MY DEPENDENTS) IN: (Only one plan and one deductible option may be selected)

[PLAN A/50 Deductible $1000 _____ $2500____
$5000 _____ $10000____

PLAN B [o Indemnity] [o Preferred Provider] Deductible $1000_____ $2500____
PLAN C [o Indemnity] [o Point of Service] [o Preferred Provider] Deductible $1000 _____ $2500____[per individual
$1500_____$2250___ per family $3000_____ $4500___]
$1650_____$2500___ per family $3300_____ $4950___]

PLAN D [o Indemnity] [o Point of Service] [o Preferred Provider] Deductible $500_____ $1000 _____ [per
individual $1500_____ $2250___per family $3000_____ $4500___]
$1650_____$2500___ per family $3300_____ $4950___]

[HMO Plan [$10] $15 [$20] [$30] copayment.] [Well Child Care Option o Yes o No]]
Basic and Essential health Care Services Plan _____
[Optional benefit Riders available with the basic and essential health care services plan (carrier should list the riders, if any)]
Type of Contract: o Single
o Family
o Adult & Child(ren)
o Husband/Wife
[o Child(ren)]
[If you selected Plan C or Plan D with a [$1500 per individual][[$[2250]**2500** per individual] [$3000 per family] [$[4500]**4950** per family] Deductible option, do you intend to participate in a Medical Savings Account?
o Yes o No]

Requested Effective Date - [Must be the 1st or 15th of the month]:_____

Type of Activity:

o New [Subscriber] o Name Change from _____ to _____

o Converting from existing (carrier) plan
ID #_____ [o Change of Primary Care Physician or Gynecologist]

[o Change of Health [Care] Center from _____ to _____]

o Add/Remove Dependent
Reason _____
Date of Event _____ [o Change of Primary Care Physician at Health [Care] Center]

o Withdrawal From Coverage
Date of Event _____

SELECT THE PAYMENT PLAN YOU DESIRE

o Monthly [o Quarterly] [o Semi-Annually]

[PAYMENT MODE:
o Check
o Money Order
[o Credit Card Type_____ No. _____ Exp. Date_____]
[o Automatic Bank Draft (attach voided check)]

[o Other _____ Amount $ _____]]

4. OTHER HEALTH CARE COVERAGE (Note: In some situations, if you are eligible for or have other health benefits coverage, you are not eligible for this [policy] [coverage]. If you or other dependents become eligible for or become covered under other health benefits coverage, after the date of this application, you must notify us as soon as possible, however no later than the effective date of such other coverage.)

Are you employed? o Yes o No If yes, please give name and address of your employer.
Are you eligible for other health benefits coverage? o Yes o No (i.e., coverage under your employer's health benefits coverage or Medicare).
If yes, give name and policy no. of other carrier or type of coverage.
Are other dependents eligible for coverage? If yes, specify.

Do you or other dependents currently have any other health care coverage? o Yes o No
If yes, give name and policy/certificate no. of other carrier, initial effective date of coverage and specify those covered by the policy/certificate:
Are you replacing existing coverage? o Yes o No
If yes, give name and policy no. of other carrier, initial effective date of coverage, date of termination, and specify those covered by policy. If you are replacing coverage and the plan is an Individual Health Coverage (IHC) Plan or a Small Employer Health Benefits (SEH) Plan, please identify the letter of the plan being replaced._____ _____ Were you, or any dependent(s) to be covered, covered under a prior Group Health Plan? o Yes o No If "Yes", attach the Certificate of Creditable Coverage
[Have you or your dependents ever been a member of [carrier]?]
[If yes, under what name and social security no.?]
[Where? [carrier] of:]

[PRE-EXISTING CONDITIONS STATEMENT
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. However, benefits, services or supplies for the treatment of a pre-existing condition may be limited for 12 months. Consult the Buyer's Guide, the carrier or your agent for information concerning the application of the pre-existing conditions limitation.

1. During the past 6 months have you, or any dependent to be covered had, or been diagnosed as having:

		Yes	No
a.	Alcoholism, 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	____	____
n.	Does Pregnancy Exist Expected Due Date: _____	____	____

2. During the past 6 months, have you or any dependent to be covered:

		Yes	No
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 medications?	____	____

Please give details for any "Yes" answers to any parts of questions 1 or 2. Attach a separate sheet if more space is needed for answers. The separate sheet should be signed and dated.

			Duration of Symptoms, Treatment Degree of		Name and Address of Hospitals,

Question	Name	Condition	Recovery	Date	Practitioners
					]

[5. PROVIDER SELECTION

	FULL NAME OF PRIMARY CARE PHYSICIAN AND OFFICE ID NO.	[HEALTH CENTER* (if applicable)]	[GYNECOLOGIST OFFICE NO.]	[ESTABLISHED PATIENT]	PRIMARY CARE PHYSICIAN CHANGE	[HEALTH CENTER CHANGE]
1. Applicant				o Yes o No	o	o
2. Spouse				o Yes o No	o	o
3. Child				o Yes o No	o	o
4. Child				o Yes o No	o	o
5. Child				o Yes o No	o	o]
[Statewide Physician Network o Health Center o]						

[*When selecting Health Center option, please also select a Primary Care Physician from among the Health Center doctors.]

[NOTE: A Primary Care Physician **must be selected** for each adult member and a Pediatrician must be selected for each child. Women over the age of 16 must also select a GYN.]

[5.][6.] AUTHORIZATION AND CERTIFICATION

I hereby apply to [carrier] for coverage for any eligible dependents listed above and myself.

[I have been offered the opportunity to add the following coverage(s) to the New Jersey Individual Health Benefits Plan and I accept or reject, as shown below: Coverage for treatment of cancer by dose intensive chemotherapy/autologous bone marrow transplants and peripheral blood stem cell transplants pursuant to New Jersey Assembly Bill 1997, P.L. 1995, c.100. o Accept o Reject]

I understand that for the 12 months following the effective date of this [policy] [contract], benefits are not provided for health care services received for (a) conditions for which medical advice, diagnosis, care or treatment was recommended or received during the last 6 months, (b) conditions for which during the last 6 months there were symptoms which would cause a prudent person to seek medical advice, diagnosis, care, or treatment, or (c) pregnancy existing on the effective date of this [policy] [contract]. (Note: This limitation will not apply if you are a Federally Defined Eligible Individual and may not apply if the eligible person transfers from another health benefits plan.)

[[Unless I request otherwise in writing,] I understand that by signing below when I file a claim, [carrier] may pay the health care benefits directly to the provider instead of to me.]

I agree that: (a) any physician, hospital or other provider is authorized to provide to [carrier or its assignee] information about any eligible person's medical history; and (b) any company or person having information concerning other health care coverage in force, or available to, any eligible person may give such information to [carrier or its assignee.]

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

I state that: (a) I am a resident of New Jersey [and reside live or work within the [carrier] service area (if applicable)], (b) the information given on this application is complete to the best of my knowledge and belief and (c) that [carrier] will rely on this information to determine eligibility. I understand that if I omit or falsify any statement in this application [carrier] can cancel this contract [as of the original effective date][immediately].

Applicant's Signature: _____ Date Signed _____

Spouse's Signature_____ Date Signed _____

Preparer's Signature: _____ DOBI License # _____ Date Signed _____

NOTE TO ALL APPLICANTS: If we accept your application, a copy of the application will be sent to you. Attach the copy to your [contract] [policy]. It becomes part of your contract with us.

For [Carrier] [Plan] Use Only	[Effective Date]	[Billing]	[Coverage Code]	[Type]	[Pre-Ex]	[Continuous Coverage]	[Transcode]	[ ]

[[6][7] AGENT/PRODUCER INFORMATION

[To be supplied by Carrier, and limited in scope to information concerning the agent/broker]]