APPENDIX EXHIBIT 1B

[Carrier Logo][1] **Application/Change Request**

[Carrier Name][2]

A. Type of Activity –Refer to instructions [on back][3] before completing this form. Print clearly.

1. Enrollment □ New [Enrollee/Subscriber][4] Requested Effective Date ___/___/___

2. Change – Check all that apply | Date of Event | Reason
   - □ Add Spouse ___/___/___ _____
   - □ Add Dependent Child ___/___/___ _____
   - □ Name Change ___/___/___ _____
   - □ Change Plan ___/___/___ _____
   - □ Other ___/___/___ _____
   - □ [Add/Change Office ID Numbers: Primary / Ob/Gyn][5]

3. Remove or Terminate – Check all that apply | Effective Date | Reason
   - □ Remove Applicant* ___/___/___ _____
   - □ Remove Spouse* ___/___/___ _____
   - □ Remove Dependent Child* ___/___/___ _____

* Please complete *Add/Change/Remove* and *Name* columns in Section D.

B. [Applicant] Information – Complete Sections [B-H][6]

Last name, First name, M.I. _____

Social Security Number_____ Home Telephone _____ Work Telephone _____

Home address_____ Apt. No ___ City, State_____ Zip Code _____

Primary Residence_____ Apt. No ___ City, State_____ Zip Code _____

Are you a Resident of the State of New Jersey? □ Yes □ No

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

If "Yes" name of state _____ How much time do you spend there each year? _____

C. Plan Option –Check one:

[Indicate Plan Names/Copays/Deductibles/Coinsurance][7]

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][8]

	(A)dd (C)hange (R)emove	Last Name,. First Name, M.I	Sex M F	Birthdate MM DD YYYY	Social Security Number	[Primary Office ID Number][9]	[Current Patient][10]	[Ob/Gyn Office ID Number (if applicable)[11]	[Current Patient]]	Previous Coverage Check if yes
[Applicant]	____	_____	_____	___/____/____	_____	_____	_____	_____	_____	____
Spouse	____	_____	_____	___/____/____	_____	_____	_____	_____	_____	____
Child	____	_____	_____	___/____/____	_____	_____	_____	_____	_____	____
Child	____	_____	_____	___/____/____	_____	_____	_____	_____	_____	____
Child	____	_____	_____	___/____/____	_____	_____	_____	_____	_____	____
Child	____	_____	_____	___/____/____	_____	_____	_____	_____	_____	____
Child	____	_____	_____	___/____/____	_____	_____	_____	_____	_____	____

[E. Pre-Existing Conditions Statement] [12]

[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.

1. During the past 6 months, have you or any dependent to be covered had or been diagnosed as having any of the following? If "Yes," check appropriate box(es) below.

Yes No

- □ □ □ a. Alcoholism or 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_____

Yes No 2. During the past 6 months, have you or any dependent to be covered:

- □ □ 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 medication?

Please give details for "Yes" answers to any part of Questions 1 or 2 on a separate sheet of paper. This separate sheet should be signed and dated.]

[F]. Previous Insurance

If yes to previous coverage provide the following

Name	Individual or Group Other (specify)	Plan Type Indemnity/PPO POS/HMO	Deductible	Coinsurance	Copay	Effective Date	Termination Date	Carrier Name	Policy Number
_____	_____	_____	_____	_____	_____	_____	_____	-_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	-_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	-_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	-_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	-_____	_____

[G]. Dependent Information

Does any dependent listed in Section D live at a different address than the [Applicant]? □Yes □No If "Yes" identify the individual(s) and at what address?

_____

Explain the circumstances.

_____

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

_____

[H] Availability of Coverage

Are you or any person named on this application eligible for coverage under a group or governmental plan, a church plan, Medicare, Medicaid or any successor program? □ Yes □ No

If "Yes" identify the individual(s), give name of carrier, policy number and identify coverage type.

_____

Are you or any person named on this application covered under a group or governmental plan, a church plan or Medicare? □ Yes □ No

If "Yes" identify the individual(s), give name of carrier, policy number and identify coverage type.

_____

Was previous coverage, if any, terminated because a person covered under the plan committed fraud or for failure to pay premiums? □ Yes □ No

If "Yes" identify the individual(s), and briefly describe the circumstances.

_____

Were any of the individuals to be covered under an individual plan given the opportunity to continue previous coverage, if any, under COBRA or a similar state continuation law? □ Yes □ No

If "Yes" did the individual(s) remain covered for the entire period that continuation was available to him or her? □ Yes □ No

Identify any person who did not continue for entire period available.

_____

Were any of the individuals to be covered under an individual plan, as of the date of this application, continuously covered under a previous plan or plans for a period of 18 or more months? □ Yes □ No

If "Yes" identify the individual(s)

_____

[I] Payment Information

□ Monthly [□ Quarterly][13]

Payment Instrument: □ Check □ Money Order □ Credit Card Type _____ No._____ Exp. Date _____

□ Automatic Bank Draft (attach voided check)

[J] [Applicant] Signature *If you have questions concerning the benefits and services provided by or excluded under this [Policy][14] contact a [Member Services][15] representative at [phone number][16] before signing this form.*

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 applicant] copy of this application/ change request.

[Applicant]Signature – Required X _____ Date ___/___/___ E-Mail Address _____

[[Applicant] copy may be used as a temporary ID card for 30 days from the effective date if authorized by [carrier]. Coverage must be verified with [Carrier name] prior to visiting a specialist or admission to a hospital.][17]

[K]. Broker/General Agent Information

Signature of Preparer: _____ Date ___/___/___ NJ Producer License #: _____

General Agent: _____ Agent ID #: _____][18]

[Internal Carrier Form Number][19]

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 Eligibility Requirements 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 are 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 coverage shall be January 1 of the following calendar year. Current coverage should not be terminated until new coverage is in effect.

Instructions

Section A – Type of Activity
Provide all information that applies to the reason you are completing this application/change form.
Section B – [Applicant] Information:
Complete all information in order for your application to be processed.
Section C – Plan Option:
[Check one Plan Option box, indicate Plan Option Name (where applicable) and check one Copay and/or Individual Deductible Amount (if applicable).]
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 listed.
- [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 the limiting age, attach proof of disability]
- [From the appropriate provider directory, locate the [6-digit] office ID number for the primary care physician, ob/gyn (if applicable). Indicate 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
Section [F] - Previous Insurance
Complete this section for all new enrollments or coverage changes. Coverage includes individual or group coverage, governmental coverage, a church plan, or Medicare or Medicaid (including NJ FamilyCare) .
Section [G] – Dependent Information
Complete this section for all new enrollments or coverage changes

Section [J] – [Applicant] Signature:

- Complete this section for all new enrollments, coverage changes and terminations.
- [Applicant] must sign and date the Application/Change Request Form in order for it to be processed.

Conditions of Enrollment
[Applicant] 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 to [Carrier Name], 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 [Carrier Name] 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 that I have a 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 a [Carrier Name] individual [policy] coverage is provided by [Carrier Name] in accordance with the contract.
3. Enrollment of myself and of the listed dependents into the plan is effective on acceptance by [Carrier Name].
4. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the [policy].

Misrepresentation

5. Any person who includes any false or misleading information on an Application/Change Request Form for a health benefits plan is subject to criminal and civil penalties.

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[1] Replace bracketed text with carrier's logo, or omit.
[2] Replace bracketed text "carrier name" with carrier's full name throughout the document.
[3] Replace "on back" with appropriate directions if the instructions are not provided on the reverse side.
[4] If the carrier refers to the "Enrollee/Subscriber" using another term such as "Member" or "Applicant" or some similar term, replace the term "Enrollee/Subscriber" with such other term throughout the document.
[5] Omit one or more "Add/Change Office ID Numbers" options if carrier does not offer such options.
[6] Re-letter sections F – H accordingly if "Section E Pre-Existing Conditions Statement is being omitted.
[7] Insert carrier plan options and deductibles, coinsurance or copayment options. The listed options must be consistent with the requirements of N.J.A.C. 11:20-3.
[8] If the carrier does not want the proof of full-time student status provided with the enrollment form and/or proof of disability, omit the directions to attach proof.
[9] Omit "Primary Office ID Number" section if the plan does not require the selection of a Primary Care Physician.
[10] Omit "Current Patient" section if the carrier does not require.
[11] Omit "Ob/Gyn Office ID Number" section if the plan does not require the selection of an Ob/Gyn Physician.
[12] The text "and pre-existing conditions statement" should be omitted if the carrier does not elect to include the pre-existing conditions statement text as part of the standard application form. Re-letter succeeding sections**.**

[13] Omit if a quarterly payment mode is not available.
[14] If the carrier refers to the "Policy" using another term such as "Plan," "Contract," or some similar term, replace the term "Policy" with such other term throughout the document.
[15] If the carrier refers to "Member Services" using another term such as "Claim Office" or "Customer Service" or some similar term, replace the term "Member Services" with such other term.
[16] Insert carrier's phone number.
[17] Carrier should insert the procedure to be followed to allow the applicant to secure coverage before the actual ID card is issued.
[18] Omit if the carrier does not use agents in the sale of individual plans. The text of this Broker/General Agent section may be modified to include the specific broker/general agent information the carrier requires. The scope of the information included in this section is limited to information concerning the broker/general agent or agent.
[19] Available for carriers that use an internal number in addition to the identifying form number.