GROUP ENROLLMENT/CHANGE REQUEST

[Carrier Logo]	Group Information – to be completed by [Employer]:		
[Carrier Name]	Group Name:	[Group Number]:	[Class Code]:

A. Type of Activity – to be completed by [Employer]. *Refer to instructions [on back] before completing this form. Print clearly.*

	Activity – Check all that apply	Effective Date/ Date of Event	Date of Hire/Reason for Change
1. ADD	☐ Enrollment of a new [Enrollee/Subscriber] ☐ Add Spouse[/Civil Union Partner] [☐Civil Union Partner] ☐ Add Domestic Partner ☐ Add Dependent Child ☐ Add Over-Age Child as a Dependent Under 31*(and complete section A 4)*	_____/_____/_____ _____/_____/_____ [_____/_____/_____] _____/_____/_____ _____/_____/_____ _____/_____/_____	Date of Hire: _____/_____/_____ _____ [_____] _____ _____ _____
2. REMOVE	☐ [Employee] Withdrawal/Termination ☐ Remove Spouse[/Civil Union Partner] [☐Civil Union Partner] ☐ Remove Domestic Partner ☐ Remove Dependent Child ☐ Remove Over-Age Child as a Dependent Under 31	_____/_____/_____ _____/_____/_____ [_____/_____/_____] _____/_____/_____ _____/_____/_____ _____/_____/_____	_____ _____ [_____] _____ _____ _____
3. OTHER CHANGE	☐ Name Change ☐ Change Plan ☐ Other ☐ [Add/Change Office ID Numbers: Primary/OB/Gyn/ Dentist]	_____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____	_____ _____ _____ _____

4. COVERAGE CONTINUATION

☐ For Employee
- ☐ Total Disability*
- ☐ COBRA/NJSGC
  - Length of Continuation (in months):
  - ☐ 18 ☐ 29
  - Date of Loss of Coverage: ___/___/___
  - Qualifying Event #:_____**
  - Date of Qualifying Event: ___/___/___

[Billing: ☐ Group ☐ Home (Section B)]

**Attach proof of disability*

☐ For Spouse/Civil Union Partner*
- Length of Continuation (in months):
- ☐ 18 ☐ 36
- Date of Loss of Coverage: ___/___/___
- Qualifying Event #:_____**
- Date of Qualifying Event: ___/___/___

[Billing: ☐ Group ☐ Home (what address?)
☐ Section B *OR*
☐ Section [E]]

**Civil union partners are eligible to make an election pursuant to NJSGC, if applicable.*

☐ For Dependent or Over-age Child
- ☐ COBRA/NJSGC
  - Length of Continuation (in months):
  - ☐ 18 ☐ 36
  - Loss of Coverage: ___/___/___
  - Qualifying Event #:_____**
  - Date: ___/___/___
- ☐ Dependent Under 31
  - Qualifying Event #:_____**

[Billing: ☐ Group*** ☐ Home (what address?)
☐ Section B *OR*
☐ Section [F]]

***Qualifying event #s: see list in Instructions. [***Billing through the group for a Dependent Under 31 Continuation Election requires agreement by the employer at Section [J] .]*

B. [Employee] Information – to be completed by the [Employee]	Name (Last, First, MI):	SSN:

Home

Street/Apt:_____
Street/Apt:_____
City:_____ State:_____ Zip Code: _____

Birthdate (mm/dd/yyyy): ☐ Male ☐ Female

Home Phone: (__)_____Cell Phone: (__)_____

[Email: _____]

Work

[Employer] Name:_____
Address:_____
City:_____ State:_____ Zip Code: _____

Work Phone: (__)_____Cell Phone: (__)_____
[Email: _____]
Employment Date: _____/_____/_____
Hours worked per week:_____

Activity

☐ Add ☐ Remove ☐ Continuation ☐ Other Change *If a name change, indicate prior name:*

[Primary Loc #:]_____ [NPI #:] [Current Patient: ☐ Yes ☐ No]
address: zip+4]

[Ob/Gyn Loc #:]_____ [NPI #:] [Current Patient: ☐ Yes ☐ No]
address: zip+4]

[Dentist Loc #:]_____ [NPI #:] [Current Patient: ☐ Yes ☐ No]
address: zip+4]

Other Health Coverage? ☐ Yes ☐ No *If yes:*
Payer Name: _____
Policy #: _____
Medicare ID#, if any:

[Other Rx Coverage? ☐ Yes ☐ No *If yes:*
Payer Name: _____
Policy #: _____
Medicare ID#, if any:]

C. Plan Option – to be completed by the [Employee] *Check one [Plan Name] [and] [Copay] [and] [or] [Deductible] [and] [or] [Coverage Status]*

D. Other Individuals Covered – to be completed by the [Employee] *Identify individuals other than yourself for whom you are adding/changing/removing/continuing coverage. Attach additional pages if necessary, with your signature and dated. [Attach proof of disability.]*

1. Spouse; Domestic or Civil Union Partner	**2.Child**	**3. Child**	**4. Child**
☐Add ☐ Remove ☐Other ☐Continue Spouse ☐Continue CU Partner (NJSGC)	☐ Add ☐ Remove ☐ Other ☐ Continue	☐ Add ☐ Remove ☐Other ☐ Continue	☐ Add ☐ Remove ☐Other ☐ Continue
Name (last, first, MI) L:_____ F:_____ MI:	Name (last, first, MI) L:_____ F:_____ MI:	Name (last, first, MI) L:_____ F:_____ MI:	Name (last, first, MI) L:_____ F:_____ MI:
Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):
☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Social Security Number:	Social Security Number:	Social Security Number:	Social Security Number:

Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name: _____ Policy #: _____ Medicare ID #:	Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name: _____ Policy #: _____ Medicare ID #:	Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name: _____ Policy #: _____ Medicare ID #:	Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name: _____ Policy #: _____ Medicare ID #:
[Other Rx Coverage: ☐ Yes ☐ No *If yes:* Payer Name: _____ Policy #: _____ Medicare ID #:]	[Other Rx Coverage: ☐ Yes ☐ No *If yes:* Payer Name: _____ Policy #: _____ Medicare ID #:]	[Other Rx Coverage: ☐ Yes ☐ No *If yes:* Payer Name: _____ Policy #: _____ Medicare ID #:]	[Other Rx Coverage: ☐ Yes ☐ No *If yes:* Payer Name: _____ Policy #: _____ Medicare ID #:]
[Primary Care Provider: NPI#:_____ Address:_____ _____ _____zip+4_____ [Current Patient? ☐Yes ☐ No]]	[Primary Care Provider: NPI:_____ Address:_____ _____ _____ zip+4 _____ [Current Patient? ☐ Yes ☐ No]]	[Primary Care Provider: NPI#:_____ Address:_____ _____ _____zip+4_____ [Current Patient? ☐Yes ☐ No]]	[Primary Care Provider: NPI#:_____ Address:_____ _____ _____zip+4 _____ [Current Patient? ☐Yes ☐ No]]
[Ob/Gyn Office NPI#:_____ Address:_____ _____ _____ zip+4_____ [Current Patient? ☐Yes ☐ No ☐ NA]]	[Ob/Gyn Office NPI#:_____ Address:_____ _____ _____zip+4_____ [Current Patient? ☐ Yes ☐ No ☐ NA]]	[Ob/Gyn Office NPI#:_____ Address:_____ _____ _____zip+4_____ [Current Patient? ☐ Yes ☐ No ☐ NA]]	[Ob/Gyn Office NPI#:_____ Address:_____ _____ _____zip+4_____ [Current Patient? ☐Yes ☐No ☐ NA]]

[Dentist Office NPI#:_____ Address:_____ _____ _____zip+4_____ [Current Patient? ☐Yes ☐ No]]	[Dentist Office NPI#:_____ Address:_____ _____ _____zip+4_____ [Current Patient? ☐Yes ☐ No]]	[Dentist Office NPI#:_____ Address:_____ _____ _____zip+4_____ [Current Patient? ☐Yes ☐ No]]	[Dentist Office NPI#:_____ Address:_____ _____ _____zip+4_____ [Current Patient? ☐Yes ☐ No]]
Employed? ☐ Yes ☐ No *If yes, complete Section [E]1*	If last name is different from [Employee's], please explain: _____ _____	If last name is different from [Employee's], please explain: _____ _____	If last name is different from [Employee's], please explain: _____ _____
Home or billing address same as [Employee]? ☐ Yes ☐ No *If NO, complete Section [E]2*	Living with [Employee]? ☐ Yes ☐ No *If NO, complete Section [F]*	Living with [Employee]? ☐ Yes ☐ No *If NO, complete Section [F]*	Living with [Employee]? ☐ Yes ☐ No *If NO, complete Section [F]*

E. Additional Spouse/Civil Union Partner/Domestic Partner Information – to be completed by [Employee] If *not applicable, please mark as "NA."*

1. Employer Name:_____
   Employer Address:_____
   City, State, Zip Code:_____
   Employer Phone: ( )

2a.
Street/Apt:_____
Street/Apt:_____
City, State, Zip Code:_____

2b. Please explain why the address is different:
_____
_____

F. Additional Child Information – to be completed by [Employee]. *Provide information below about children listed in Section D,* **if** *they have a different address from the employee. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated*.

Name(s):_____
Street/Apt:_____
Street/Apt:_____
City, State, Zip Code: _____
Reason:_____

Name(s):_____
Street/Apt:_____
Street/Apt:_____
City, State, Zip Code:_____
Reason:_____

[G.] Race/Ethnicity – The federal government is collecting information on race and ethnicity on covered persons. Enter a numbered code for race and ethnicity that best describes each person you are seeking to cover. You can choose up to three categories of race and two categories of ethnicity per person. Add additional pages if necessary for additional children. *Response is appreciated but NOT required! Choose a category that most closely describes you:*

Race				Ethnicity	
1	White	11	Other Asian	1	Hispanic
2	Black or African American	12	Native Hawaiian or Other Pacific Islander	2	Not Hispanic

3	American Indian or Alaska Native	13	Native Hawaiian	3	Cuban
4	Asian	14	Guamanian or Chamorro	4	Mexican, Mexican American, Chicano/a
5	Asian Indian	15	Samoan	5	Puerto Rican
6	Chinese	16	Other Pacific Islander	6	An Ethnicity Not Listed Above
7	Filipino	17	Middle Eastern or North African	7	Unknown
8	Japanese	18	Another Race Not Listed Above	8	Decline to Respond
9	Korean	19	Unknown		
10	Vietnamese	20	Decline to Report		

Covered Person	Race Code	Race Code	Race Code	Ethnicity Code	Ethnicity Code
Applicant					
Spouse					
Child 1					
Child 2					
Child 3					

H. [Employee] Signature	I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I authorize deductions from my earnings for any contributions required from me. Signature: _____ Date: _____
I. Over-Age Child's Signature	I represent that all the information supplied in this application regarding the [Dependent Under 31] Continuation Election is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. [I hereby agree to make contributions required from me for the Dependent Under 31 Continuation Election.] Signature: _____ Date: _____
J. [Employer] Verification	The requested activity is believed eligible and is approved by the [Employer]. [In addition, the [Employer] consents to payroll deduction for Dependent Under 31 Continuation Election: ☐ Yes ☐ No] Employer Representative: _____ Date: _____ Representative's Title: _____

CONDITIONS OF ENROLLMENT -- [APPLICANT] ACKNOWLEDGEMENTS AND AGREEMENTS

On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer reporting agency, and any employer to give [Carrier Name], or any consumer reporting agency acting on behalf of [Carrier Name], information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that [Carrier Name] has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one.
4. I agree [Carrier] will provide coverage in accordance with the terms of the contract for the group [plan] [policy].
5. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the group [plan] [policy] if premiums are not paid timely. I authorize my Employer to withhold payments from my wages as contribution to the premium, as appropriate.

INSTRUCTIONS

[Employers] – You must complete the [Employer] Group Information and sections A and J in order for this application to be processed.

[Employees] – You must complete sections B through H and submit the signature of each Over-Age Child for which a Dependent Under 31 Continuation Election is made in accordance with Section I in order for this application to be processed.

- Please PRINT except when a signature is requested.
- If a dependent is disabled and you want to continue his or her coverage beyond age 26, you do not have to make a COBRA/NJSGC or Dependent Under 31 election. Instead, select "Other" in Section A3, and attach proof of disability.
- For provider addresses, include the zip code plus the four digit extension (11 digits)
- You can obtain the providers' correct names and addresses from the appropriate provider directory. You may also obtain each provider's NPI number [from the provider directory] [or] [and] [at: URL] [or] [and] [by contacting the provider directly.] Providers with multiple office locations and individual providers who belong to more than one practice or provider entity may have more than one NPI number. You should confirm the correct NPI number for the specific provider and office location where you will be seen by contacting that office directly.

Qualifying Events

COBRA and NJSGC
C1. Termination of job or reduction in hours
C2. Employee enrollment in Medicare (COBRA only)
C3. Divorce (COBRA/NJSGC); civil union dissolution (NJSGC)
C4. Death of employee
C5. Loss of dependent child status under the plan
C6. Disability (occurring subsequent to another qualifying event)
Dependent Under 31
D1. Loss of dependent status and otherwise eligible
D2. Reestablish eligibility: residency
D3. Reestablish eligibility: nonresident full-time student
D4. Reestablish eligibility: change in marital status
D5. Reestablish eligibility: change in parental status
D6. Reestablish eligibility: termination of other coverage

Carrier instructions

(not to be included in the Enrollment/Change Request form when printed by the carrier)

1. Carrier should insert its logo and name where indicated, or leave the table blank, or blacked-out.
2. Carrier must replace bracketed text "carrier name" with carrier's full name throughout the document.
3. If the carrier refers to the "Employer" using another term such as "Planholder" or "Contractholder" or some similar term, replace the term "Employer" with such other term throughout the document.
4. If the carrier refers to "Group Number/Class Code" using some other term such as "Policy Number," "Control Number" or some similar term, replace the term "Group Number/Class Code" with such other term.
5. Replace "on back" with appropriate directions if the instructions are not provided on the reverse side.
6. 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.
7. In Section A1 and 2, the carrier may choose to put Civil Union Partner on the same line as Spouse, or insert new lines for Civil Union Partner separately.
8. In Section A, omit "Add/Change Office ID Numbers" options if carrier does not offer such options.
9. In Section A, the continuation billing options should be omitted if the carrier does not offer such options. In addition, the phrase "******Billing through the group for a Dependent Under 31 Continuation Election requires agreement by the employer at Section J"*** if the carrier does not offer the Integrated continuation coverage option.
10. In Section B, references to the employee's e-mail address should be omitted if the contact option is not offered.
11. At Section B and D, references to primary, ob/gyn and dentist selections should be omitted if selections are not an option or a requirement. If a carrier does not assign numbers for each office location, then carriers may indicate that LOC refers to the office location in the selection information, and request that enrollees identify a name for the office location. However, carriers should not request complete office address locations.
12. At Section B and D, reference to current patient information should be omitted if the carrier does not require it.
13. At Section C, insert carrier plan options and deductibles, coinsurance or copayment options, and provide directions for employee/enrollee selections of options as appropriate.
14. At Section D1, the carrier may elect not to reference Domestic Partner if an employer does not permit coverage of Domestic Partners.
15. At Section D1, the carrier may indicate that continuation is an option for "Spouse only" for groups subject ONLY to COBRA.
16. At Section D, requests for information about other prescription drug coverage are optional.
17. At Section D, if the carrier does not require proof of disability, omit the directions to attach proof.
18. At Section E, carriers may omit Domestic Partners if the employer does not allow coverage for domestic partners.
19. At Section J, omit "In addition, the [Employer] consents to payroll deduction for Dependent Under 31 Continuation Election: ☐ Yes ☐ No" if the carrier does not offer the Integrated continuation coverage option.
20. At Instructions, if you require selection of health care providers, insert appropriate information on how to obtain correct NPI numbers. Note that indicating information is available only through a website is not appropriate.
21. At the Footnote, if a carrier does not utilize an "Internal Carrier Form Number," the carrier may omit the reference.