NONGROUP ENROLLMENT/CHANGE REQUEST

[Carrier Logo]

[Carrier Name]

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

	Activity – Check all that apply	Effective Date/ Date of Event	Reason
ADD	☐ Enrollment of a new [Insured/Enrollee/Subscriber]	_____/_____/_____	_____
	☐ Add Spouse[/Civil Union Partner]	_____/_____/_____	_____
	[☐ Add Civil Union Partner]	[_____/_____/_____]	[_____]
	☐ Add Domestic Partner	_____/_____/_____	_____
	☐ Add Dependent Child	_____/_____/_____	_____
REMOVE	☐ Remove [Insured/Enrollee/Subscriber]	_____/_____/_____	_____
	☐ Remove Spouse[/Civil Union Partner]	_____/_____/_____	_____
	[☐ Remove Civil Union Partner]	[_____/_____/____]	[_____]
	☐ Remove Domestic Partner	_____/_____/_____	_____
	☐ Remove Dependent Child	_____/_____/_____	_____
OTHER CHANGE	☐ Name Change	_____/_____/_____	_____
	☐ Change Plan	_____/_____/_____	_____
	☐ Other	_____/_____/_____	_____
	☐ [Add/Change Office ID Numbers: Primary/OB/Gyn]	_____/_____/_____	_____

B. [Applicant] Information Name (Last, First, MI):

SSN: | Birthdate (mm/dd/yyyy) | ☐ Male ☐ Female | [Email:]

Are you a resident of New Jersey? ☐ Yes ☐ No

Do you maintain a home in any other state? ☐ Yes ☐ No *If yes:*
Name of State:_____ Number of months you live there each year: _____

Address Information

Primary Residence:
Street/Apt:_____
Street/Apt:_____
City:_____ State:_____
Zip Code: _____
Phone: (_____)_____

Other Residence:
Street/Apt:_____
Street/Apt:_____
City:_____ State:_____
Zip Code: _____
Phone: (_____)_____

Your billing address: ☐ Primary residence ☐ Other residence ☐ P.O. Box or Other *(specify)*:

Activity

☐ Add ☐ Remove ☐ Other Change ☐ Continue *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

Are you covered under Other Health Coverage? ☐ Yes ☐ No *If yes:* Payer Name: _____ Policy #: _____ Medicare ID#, if any: Why are you applying for individual coverage? _____	Are you **eligible but not covered** under Other Health Coverage? ☐ Yes ☐ No *If yes, what is it?* ☐ Group plan via employment (*specify payer*): _____ ☐ Medicaid/NJFamilyCare ☐ Medicare ☐ Other (*specify*): _____

Previous Coverage? ☐ Yes ☐ No *If Yes:* Effective date: _____/_____/_____ Termination date: _____/_____/_____ Payer Name:_____ Policy #:_____ [*Submit a Certificate of Creditable Coverage*]	What was it? ☐ Individual ☐ Group ☐ Medicaid/NJFamilyCare ☐ Other *(specify):*	What Plan Type? ☐ Indemnity ☐ PPO ☐ POS ☐ HMO ☐ Other	Cost-sharing requirements: Deductible amount: $_____ Coinsurance amount: _____% Copayment amount: $_____

Did coverage terminate as a result of fraud or failure to pay premiums?	☐ Yes ☐ No
Were you allowed to make a COBRA continuation election, or a continuation election under State law, if any, when coverage ended?	☐ Yes ☐ No
If Yes, did you elect to continue and remain covered for the entire continuation period available to you?	☐ Yes ☐ No
Were you covered for 18 months or more under any previous plan(s)?	☐ Yes ☐ No
Have you experienced more than a 63-day break in coverage between any previous plan, including your most recent plan and the date of this application?	☐ Yes ☐ No

C. Plan Option – *Check one [Plan Name] [and] [Copay] [and] [or] [Deductible] [and] [or] [Coverage Status]*

D. Other Individuals Covered – *Identify individuals other than yourself for whom you are adding/changing/removing coverage. Attach additional pages if necessary, dated and signed by you.. [Attach proof of disability.]*

1. Spouse/Domestic Partner/Civil Union Partner	**2. Child**	**3. Child**	**4. Child**
☐ Add ☐ Remove ☐ Other	☐ Add ☐ Remove ☐ Other	☐ Add ☐ Remove ☐Other	☐ Add ☐ Remove ☐Other
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:

Previous Coverage?
☐ Yes ☐ No
If yes:
Effective:____/____/___
Termination: ___/___/___
Payer:_____
Policy #: _____

What was it?
☐ Individual
☐ Group
☐ Medicaid/NJFamilyCare
☐ Other *(specify):*
_____

What Plan type?
☐ Indemnity ☐ PPO
☐ POS ☐ HMO
☐ None of the above

Cost-sharing requirements:
Deductible: $_____
Coinsurance: _____%
Copayment: $_____

Why did coverage end?
_____

Was continuation upon termination an option?
☐ Yes ☐ No
If yes, was continuation elected and coverage retained for full continuation period?
☐ Yes ☐ No

Does total previous coverage equal 18 months or more?
☐ Yes ☐ No

Any breaks in coverage of more than 63 days?
☐ Yes ☐ N
[*submit a copy of the Certificate of Creditable Coverage*]

Previous Coverage?
☐ Yes ☐ No
If yes:
Effective:____/____/___
Termination: ___/___/___
Payer :_____
Policy #: _____

What was it?
☐ Individual
☐ Group
☐ Medicaid/NJFamilyCare
☐ Other *(specify):*
_____

What Plan type?
☐ Indemnity ☐ PPO
☐ POS ☐ HMO
☐ None of the above

Cost-sharing requirements:
Deductible: $_____
Coinsurance: _____%
Copayment: $_____

Why did coverage end?
_____

Was continuation upon termination an option?
☐ Yes ☐ No
If yes, was continuation elected and coverage retained for full continuation period?
☐ Yes ☐ No

Does total previous coverage equal 18 months or more?
☐ Yes ☐ No

Any breaks in coverage of more than 63 days?
☐ Yes ☐ N
[*submit a copy of the Certificate of Creditable Coverage*]

Previous Coverage?
☐ Yes ☐ No
If yes:
Effective:____/____/___
Termination: ___/___/___
Payer:_____
Policy #: _____

What was it?
☐ Individual
☐ Group
☐ Medicaid/NJFamilyCare
☐ Other *(specify):*
_____

What Plan type?
☐ Indemnity ☐ PPO
☐ POS ☐ HMO
☐ None of the above

Cost-sharing requirements:
Deductible: $_____
Coinsurance: _____%
Copayment: $_____

Why did coverage end?
_____

Was continuation upon termination an option?
☐ Yes ☐ No
If yes, was continuation elected and coverage retained for full continuation period?
☐ Yes ☐ No

Does total previous coverage equal 18 months or more?
☐ Yes ☐ No

Any breaks in coverage of more than 63 days?
☐ Yes ☐ N
[*submit a copy of the Certificate of Creditable Coverage*]

Previous Coverage?
☐ Yes ☐ No
If yes:
Effective:____/____/___
Termination: ___/___/___
Payer:_____
Policy #: _____

What was it?
☐ Individual
☐ Group
☐ Medicaid/NJFamilyCare
☐ Other *(specify):*
_____

What Plan type?
☐ Indemnity ☐ PPO
☐ POS ☐ HMO
☐ None of the above

Cost-sharing requirements:
Deductible: $_____
Coinsurance: _____%
Copayment: $_____

Why did coverage end?
_____

Was continuation upon termination an option?
☐ Yes ☐ No
If yes, was continuation elected and coverage retained for full continuation period?
☐ Yes ☐ No

Does total previous coverage equal 18 months or more?
☐ Yes ☐ No

Any breaks in coverage of more than 63 days?
☐ Yes ☐ N
[*submit a copy of the Certificate of Creditable Coverage*]

Covered under Other Health Coverage Now? ☐ Yes ☐ No *If yes:* Payer Name: ______________________ Policy #: ______________ Medicare ID #:___________ **Eligible but not** covered under Other Health Coverage? ☐ Yes ☐ No *If Yes*, identify the type: ☐Group Payer:__________________ ☐Medicare ☐Medicaid/NJFamilyCare ☐Other (*specify*) ______________________	Covered under Other Health Coverage Now? ☐ Yes ☐ No *If yes:* Payer Name: ______________________ Policy #: ______________ Medicare ID #:___________ **Eligible but not** covered under Other Health Coverage? ☐ Yes ☐ No *If Yes*, identify the type: ☐Group Payer:__________________ ☐Medicare ☐Medicaid/NJFamilyCare ☐Other (*specify*) ______________________	Covered under Other Health Coverage Now? ☐ Yes ☐ No *If yes:* Payer Name: ______________________ Policy #: ______________ Medicare ID #:___________ **Eligible but not** covered under Other Health Coverage? ☐ Yes ☐ No *If Yes*, identify the type: ☐Group Payer:__________________ ☐Medicare ☐Medicaid/NJFamilyCare ☐Other (*specify*) ______________________	Covered under Other Health Coverage Now? ☐ Yes ☐ No *If yes:* Payer Name: ______________________ Policy #: ______________ Medicare ID #:___________ **Eligible but not** covered under Other Health Coverage? ☐ Yes ☐ No *If Yes*, identify the type: ☐Group Payer:__________________ ☐Medicare ☐Medicaid/NJFamilyCare ☐Other (*specify*) ______________________
[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]]
Employed? ☐ Yes ☐ No *If yes, complete Section [F]1*	If last name is different from [Applicant's], please explain: ____________________ ____________________	If last name is different from [Applicant's], please explain: ____________________ ____________________	If last name is different from [Applicant's], please explain: ____________________ ____________________

Home address same as [Applicant]? ☐ Yes ☐ No *If NO, complete Section [F]2*	Living with [Applicant]? ☐ Yes ☐ No *If NO, complete Section [G]*	Living with [Applicant]? ☐ Yes ☐ No *If NO, complete Section [G]*	Living with [Applicant]? ☐ Yes ☐ No *If NO, complete Section [G]*

[**E. Preexisting Conditions** – This section must be completed with respect to all persons to be covered who are age 19 or older. This section does not apply to any person under age 19. *Check all that apply. If you check one of the conditions in #1, or respond yes to any question in #2, give details on a separate sheet of paper. This separate sheet must be signed and dated by you.* 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 may only use the information to expedite the processing of claims.]

[1. If you or any dependent to be covered who is age 19 or older has been diagnosed as having any of the following within the past 6 months, please place a check mark in the appropriate box:]

[☐ 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/Condition /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 a pregnancy exist?
If so, provide expected due date: _____]

[2. During the past 6 months, have you or any dependent to be covered who is age 19 or older:] [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 medication?] ☐ ☐]

[F.] Additional Spouse/Domestic Partner/Civil Union Partner Information – *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:
_____
_____

[G.] Additional Child Information – *Provide information below about children listed in Section D, if they have a different address. 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:_____

[H.] Race/Ethnicity – *Response is appreciated but NOT required!*

Choose a category that most closely describes you: ☐American Indian or Alaskan Native ☐Black, not of Hispanic origin ☐Hispanic ☐Asian or Pacific Islander ☐White, not of Hispanic origin

[I.] Payment Information – *indicate how you would like to [be billed and] make payment*

[☐ Monthly ☐ Check
[☐ Quarterly] ☐ Money Order
[☐ Semi-annually]] [☐Automatic Bank Draft (*attach voided check*)]

[☐Credit Card Type (AMEX, Visa, etc.):_____
No.:_____ Exp. Date: ____/____/____
Cardholder Name:

[J.] [Applicant's] 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

Signature: Date:

[K.] Broker/General Agent Signature	Signature of Preparer	Date / /	NJ Producer License #
	General Agent		Agent ID #

INSTRUCTIONS AND ELIGIBILITY REQUIREMENTS

Instructions

- ☆ Except for section [H], you must complete sections A through [J], and sign and date this form, as well as any additional pages you may need to submit with it to provide further requested information.
- ☆ Please PRINT except when a signature is requested.
- ☆ If a dependent child is disabled and you want to continue his or her coverage beyond age 26, describe this in "Other Change" in Section A, and attach proof of disability.
- ☆ 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.
- ☆ For provider addresses, include the zip code plus the four digit extension (11 digits)
- ☆ "Previous Coverage" and "Other Health Coverage" includes coverage under a: group health plan resulting from employment, whether with a private or public (governmental) employer, including such coverage continued through a COBRA election or state continuation provisions; a church plan, Medicare, Medicaid, NJFamilyCare, or another individual health benefits plan.
- ☆ IF YOU HAVE ANY QUESTIONS concerning the benefits and services provided by or excluded under this [policy], contact a [member services] representative at [phone number] before signing this form.
- ☆ KEEP A COPY OF THIS COMPLETED APPLICATION! [A copy of this application may be used as a temporary ID card for 30 days from the effective date if authorized by [Carrier Name]. Coverage must be verified with [Carrier Name] prior to visiting with a specialist or admission to a hospital.]

Eligibility

A. Eligibility requirements are set forth under the Individual Health Coverage Reform Act of 1992, P.L. 1992, c. 161 (N.J.S.A. 17B:27A-2 et seq.).
B. You MUST be a New Jersey resident.
C. EXCEPT as F. below applies, you and family members you wish to cover MUST NOT be eligible to be covered under a: group health plan; a group health benefits plan; a governmental plan (not including Medicaid); a church plan; or Medicare.
D. 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 you are replacing the other individual health benefits plan by the one for which you are submitting this application.
E. If you do not specify an effective date in the application, your effective date shall be no later than the first or fifteenth day of the month following the date the completed application was dated and we receive premium payment directly or through our duly authorized agent UNLESS you submit your application during the November Open Enrollment Period (see F. below).
F. You may apply for coverage for yourself and family members who are covered under a group health plan, group health benefits plan, a governmental plan, a church plan or Medicare during the November Open Enrollment Period IF you wish to replace the current coverage with a more comprehensive individual health benefits plan. The effective date of coverage under the individual health benefits plan in this instance will be January 1 of the calendar year following the November Open Enrollment Period. You SHOULD NOT terminate current coverage until the new coverage is effective.

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 individual [plan] [policy].
5. I understand that my enrollment and the enrollment of my listed dependents in [Carrier's Name's] individual [plan] [policy] is effective upon acceptance by [Carrier's Name].
6. 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 individual [plan] [policy] if premiums are not paid timely.

MISREPRESENTATIONS

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

Carrier instructions

(not to be included in the Nongroup 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. 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. In Section A, carrier may choose to put Civil Union Partner on the same line as Spouse, or on a separate line.
6. In Section A, omit "Add/Change Office ID Numbers" options if carrier does not offer such options.
7. In Section B, references to the e-mail address should be omitted if the contact option is not offered.
8. At Section B and D, references to primary and ob/gyn selections, with LOC and NPI numbers should not be included 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.
9. At Section B and D, omit reference to current patient status, if the carrier does not require the information.
10. At section B and D, omit the request for the Certificate of Creditable Coverage to be submitted with the application if the carrier does not require it.
11. At Section C, insert carrier plan options and deductibles, coinsurance or copayment options, and provide directions for employee/enrollee selections of options as appropriate. Listed options must be consistent with the requirements of N.J.A.C. 11:20-3.
12. At Section D, if the carrier does not require proof of disability, omit the directions to attach proof.
13. If Section [E] is omitted, renumber Sections F through L accordingly.
14. At Section I, omit those payment options or modes that are unavailable (but note: carriers must permit payment on a monthly basis).
15. At Section [K], omit reference to agents if the carrier does not use them in the sale of individual policies. The text may be modified to include the specific broker/general agent information the carrier requires. The scope of the information included is limited to information concerning the broker/general agent or agent.
16. In the Instructions, if carrier uses a term other than "Member Services," the carrier should insert that term, and must include the appropriate contact phone number.
17. In the Instructions, carrier must insert the procedure to be followed to allow the applicant to secure coverage before the actual ID card is issued.
18. It Instructions, if you require selection of health care providers, insert appropriate information on how the to obtain correct NPI numbers. Note that indicating information is available only through a website is not appropriate.

19. At the Footnote, if a carrier does not utilize an “Internal Carrier Form Number,” the carrier may omit the reference.