

[Carrier] Non-Group Product Conversion Request Form

A. Product Change Request – to be completed by the applicant. [Requested Effective Date ___/___/___]

[Note: Carriers may expand the requested effective date to explain the effective dates that would result from an initial enrollment period, annual open enrollment period or the limited enrollment permitted for terminations in 2014.]

B. Applicant Information

Last Name: _____ First Name: _____ MI: _____

Member ID#: _____ Date of Birth: ___/___/___ [E-Mail _____]

Primary Residence: Street _____ Apt: _____

City: _____ State: _____ Zip Code: _____ Home Phone: _____

Are you still a resident of New Jersey: Yes _____ No _____

Are you or any of your dependents eligible for or covered by Medicare?

You: Yes _____ No _____ **Your Dependents:** Yes _____ No _____

C. Plan Option –Please select desired plan

[Insert Plan Options] [Primary Care Provider Selection Required] [Primary Care Provider Selection Optional]

D. [Primary Care Provider (PCP) Selection – If the plan you selected requires a PCP, please complete the following section for yourself and each covered dependent. Attach additional pages if necessary, signed and dated by you.] *(Carriers can omit this section from the form if the plans being offered do not require the selection of a PCP. If a plan encourages selecting a PCP even though it is not required, add text to encourage the completion of the PCP information.)*

1. Applicant

Last Name: _____ First Name: _____ MI: _____

Primary Care Provider Name: _____ Current Patient: Yes ___ No ___

Primary Care Provider Address: _____

City: _____ State: _____ Zip Code +4: _____

NPI #: _____ Loc Code: _____

2. Spouse/Civil Union Partner/Domestic Partner

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____

Primary Care Provider Name: _____ Current Patient: Yes ___ No ___

Primary Care Provider Address: _____

City: _____ State: _____ Zip Code +4: _____

NPI #: _____ Loc Code: _____

3. Child

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____

Primary Care Provider Name: _____ Current Patient: Yes ___ No ___

Primary Care Provider Address: _____

City: _____ State: _____ Zip Code +4: _____

NPI #: _____ Loc Code: _____

4. Child

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____

Primary Care Provider Name: _____ Current Patient: Yes ___ No ___

Primary Care Provider Address: _____

City: _____ State: _____ Zip Code +4: _____

NPI #: _____ Loc Code: _____

5. Child

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____

Primary Care Provider Name: _____ Current Patient: Yes ___ No ___

Primary Care Provider Address: _____

City: _____ State: _____ Zip Code +4: _____

NPI #: _____ Loc Code: _____

E. Payment Information – [Indicate payment options] [Do not send money now. We will bill you if you are eligible to change your coverage.]

F. Applicant's Signature

I represent that all the information supplied in this Non-Group Product Conversion Request Form is true and complete. I hereby agree to the conditions of enrollment set forth in this form.

Signature: _____ Date: ____/____/____

G. Broker/General Agent Signature

Signature of Agent: _____ Date: ____/____/____ NJ Producer License# _____

Print Agent Name: _____ [Federal Agent ID# _____]

General Agent/Broker: _____ Agent/Vendor ID# _____

Instructions

- ☆ This form is used to change from one non-group product to another non-group product. You must complete all sections and sign and date this form and any additional pages you may need to submit with it to provide further requested information.
 - ☆ Please PRINT except when a signature is requested.
 - ☆ 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)
 - ☆ 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. You must not have other health coverage besides the individual plan you currently wish to replace. "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, or another individual health benefits plan

On behalf of myself and the dependents listed in this Non-Group Product Conversion 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 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 conditioned upon acceptance by [Carrier's Name].

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 Non-Group Product Conversion Request Form for a health benefits plan is subject to criminal and civil penalties.