WELLCHOICE®

EMPLOYEE APPLICATION/CHANGE FORM
SMALL EMPLOYER BENEFITS ENROLLMENT FORM

Effective Date: ______________________

Company Name: ______________________ Policy No.: ______________________

Company Address: ______________________

SECTION I: EMPLOYEE INFORMATION

Name: ______________________ (Last / First / Middle Initial)

Residence ______________________ (Street)

______________________ (City / State / Zip Code)

Social Security #: ________ / ________ / ________

Marital Status: ❒ Single ❒ Married ❒ Widowed ❒ Divorced

Home Telephone: ______________________

Work Telephone: ______________________

Title/Occupation: ______________________

Date of Employment: ______________________

Hours worked per week: ______________________

Are you actively at work? ❒ Yes ❒ No

If "No" explain: ______________________

SECTION II: REASON FOR ENROLLMENT

New Enrollment:

❒ I am an employee of an organization which is applying for coverage
❒ I had **NO** previous coverage
❒ I had previous coverage during the past 90 days
Name of previous carrier ______________________
Plan No. __________ Start Date ____/____/____ Term Date ____/____/____
❒ I previously refused/waived coverage
Reason: ______________________
❒ I am applying for coverage during my organization's open enrollment period. Open enrollment date: ____/____/____

Continuation/Deletion of Existing Coverage:

❒ I am continuing coverage under state or federal law.
❒ COBRA Reason: ______________________ Date Began: ___/___/___
❒ New Jersey Group Continuation Date Began: ___/___/___
❒ Employee ❒ Employee and enrolled dependent(s)
❒ Total Disability (Attach proof of disability)
❒ Other (specify) ______________________
❒ I am terminating coverage for myself and all dependents
❒ I am (adding or deleting) dependents
Date of event: ____/____/____
Reason: ______________________

SECTION III: COVERAGE INFORMATION

1. **PERSONS TO BE COVERED:** ❒ Employee Only ❒ Employee & Spouse ❒ Employee & Child(ren) ❒ Employee, Spouse & Child(ren)
2. **PRODUCT SELECTION:** ❒ PPO ❒ HMO ❒ Indemnity
3. Please provide all information for each person to be covered. Attach a separate sheet to list additional children.
Attach proof of full time student status. Attach proof of disability. If dependents 19 - 22. Coverage ends on dependents 23rd Birthday.

	Last First MI	Sex	Social Security No.	Birthdate	(HMO Only) Primary Care Physician	PCP #
Employee ❒ ADD ❒ REMOVE		❒ M ❒ F	/ /	/ /		
Spouse ❒ ADD ❒ REMOVE		❒ M ❒ F	/ /	/ /		
Child ❒ ADD ❒ REMOVE		❒ M ❒ F	/ /	/ /		
Child ❒ ADD ❒ REMOVE		❒ M ❒ F	/ /	/ /		
Child ❒ ADD ❒ REMOVE		❒ M ❒ F	/ /	/ /		

SECTION III: COVERAGE INFORMATION (Continued)

4. Which coverage have you selected to be primary in the event expenses are incurred as a result of an automobile related injury?
❒ Auto ❒ Medical

5. Indicate whether you and/or your spouse, if any, are enrolled under Part A and/or Part B of Medicare

	Plan A	Effective Date	Part B	Effective Date	Medicare ID No.	
Employee	❒ Yes ❒ No	____/____/____	❒ Yes ❒ No	____/____/____	__________	❒ End Stage Renal
Spouse	❒ Yes ❒ No	____/____/____	❒ Yes ❒ No	____/____/____	__________	❒ Age (65+)
						❒ Disability

Are you or any person to be covered eligible for other health benefits coverage? ❒ Yes ❒ No

❒ Employer Sponsored Plan ❒ Medicare ❒ Medicaid ❒ Other ______________________

If yes, give name and policy number of other carrier or type of coverage: ______________________

Start Date____/____/____ Term Date____/____/____

SECTION IV: DECLARATION AND AUTHORIZATION (Continued on Back)

1. I authorize the sources stated below to give to WellChoice HMO of New Jersey, WellChoice Insurance of New Jersey, Inc., 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 care, advice, treatment or supplies for any physical or mental condition. Authorized sources are: any physician, medical professional; any hospital, clinic or other medical care institution; any carrier; any consumer reporting agency; any employer.
2. I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which WellChoice HMO of New Jersey, WellChoice Insurance of New Jersey, Inc. has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
3. I know that I have a right to receive a copy of this authorization if I request one.
4. I agree that a photocopy of this authorization is as valid as the original.

Date Signed: ______________________ Signature of Employee: ______________________

PO BOX 3509, CHURCH STREET STATION, NEW YORK NY 10008-3509

Services and products provided by WellChoice Insurance of New Jersey, Inc. and WellChoice HMO of New Jersey.

WHITE - WELLCHOICE YELLOW - WELLCHOICE PINK - WELLCHOICE GOLDEN ROD - EMPLOYEE

SECTION V

I hereby apply for the group coverage for which I am or may become entitled. I authorize deductions from my pay for my share of the cost, if any. I represent to the best of my knowledge and belief, that the statements and answers given above are true and complete. I understand that the information, other than the Pre-existing Conditions Statement information. shall form the basis upon which I may be included for coverage under the group plan.

I understand that:

a. the coverage applied for will not take effect unless:
   - the first premium has been paid to WellChoice Insurance of New Jersey, Inc./WellChoice HMO of New Jersey and
   - I am actively at work for full pay on a full time basis on the date coverage is to take effect.

b. no person, except an officer of WellChoice Insurance of New Jersey, Inc./WellChoice HMO of New Jersey has authority to: determine whether any certificate shall be issued on the basis of this Enrollment Form and Pre-existing Conditions Statement; waive or modify any of the provisions of the Enrollment Form and Pre-existing Conditions Statement or any of WellChoice Insurance of New Jersey, Inc./WellChoice HMO of New Jersey requirement; to bind WellChoice Insurance of New Jersey, Inc./WellChoice HMO of New Jersey by any statement or promise pertaining to any certificate signed or to be issued on the basis of this Enrollment and Pre-existing Conditions Statement; or except any information or representation not continued in the written Enrollment Form and Pre-existing Conditions Statement.

c. the Employer is hereby designated my representative for the purpose of receiving contributions and remitting them to WellChoice Insurance of New Jersey, Inc./WellChoice HMO of New Jersey.

d. I understand that WellChoice Insurance of New Jersey, Inc./WellChoice HMO of New Jersey does not pay benefits for charges for Pre-existing Conditions until a person covered under the Policy has been continuously covered under the Policy for 180 days.

I understand that the following are Pre-existing Conditions:

- an illness or injury which manifests itself during the 6 months prior to the date a person's coverage takes effect and for which: the person sees a Practitioner, takes prescribed drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the 6 months before coverage takes effect; or

Note: Any person who knowingly files a statement of claim, application for insurance, enrollment form or Pre-existing Conditions Statement, containing any false or misleading information may be subject to criminal and civil penalties.

CONDITIONS OF ACCEPTANCE

On behalf of myself and the dependents listed 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 WellChoice Insurance of New Jersey, Inc./WellChoice HMO of New Jersey after a review of the application and receipt of payment.

2. Applicant is applying for 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 and who are chiefly dependent upon the applicant or the applicants spouse for support and maintenance or are unmarried children between ages of nineteen (19) and twenty-three (23) who are full-time students at an accredited educational institution and receive at least half of their support from applicant and/or applicant's spouse and neither applicant's spouse nor children are eligible for group health benefits coverage.

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

4. The contract will determine the rights and responsibilities of member(s) and will govern in the event it conflicts with any benefits compensation, summary or other description of the health benefits plan.

5. As a condition to benefits, applicant understands and agrees that with the exception of emergency procedures as defined in the Contract, all services, in order to be covered by WellChoice Insurance of New Jersey, Inc./WellChoice HMO of New Jersey must be performed either by a participating primary care physician or by the participating specialist, hospital or other person provider as authorized by prior written referral from the participating primary care physician.

6. Applicant agrees to make payment directly to health care providers such copayments as are provided for in the employer's health benefits plan.

7. Applicant understands that this coverage will remain in effect regardless of the continued availability of a particular WellChoice Insurance of New Jersey, Inc./WellChoice HMO of New Jersey primary care physician or other health care provider.

8. Applicant acknowledges that WellChoice Insurance of New Jersey, Inc./WellChoice HMO of New Jersey participating providers, including all participating primary care physicians, are independent contractors and are not agents or employees of WellChoice Insurance of New Jersey, Inc./WellChoice HMO of New Jersey.