

If "Yes" to Other Health Coverage (Section D), give names & policy numbers of insurance carrier, HMO, or other source. If enrolled in Medicare Parts A and/or B identify the coverage and provide the Medicare ID #.

If "Yes" to Other Rx Drug Coverage (Section D), give name & policy number of insurance carrier, HMO, or other source.

If "Yes" to Previous Coverage, identify name(s) of persons, give effective date and date coverage terminated, name of previous carrier and plan number [, and submit a copy of the Certificate of Creditable Coverage that was issued by the previous carrier, if available.]¹⁹

[G]. Dependent Information

Does any dependent listed in Section D live at a different address than the [Employee]? Yes No If "Yes" who and at what address?

Explain the circumstances.

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

[H] [Employee] Signature *If you have questions concerning the benefits and services provided by or excluded under this [Agreement]²⁰ contact a [Member Services]²¹ representative at [phone number]²² 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 employee] copy of this enrollment/ change request. I authorize deductions from my earnings for any required contributions.

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

[I] [Employer Verification – To be Completed by [Employer]

[Employer] Signature – Required X _____ Title _____ Date ___/___/___

[[Employee] copy may be used as a temporary ID card for 30 days from the effective date if authorized by [employer]. Coverage must be verified with [Carrier name] prior to visiting a specialist or admission to a hospital.]²³

[NJ-HINT]

[Internal Carrier Form Number]²⁴

NJ-HINT-Group

[Internal Carrier Form Number]

Instructions**[Employer]**

- Complete the [Employer] Group information [in the upper right corner] of the form.
- Section A – Type of Activity: Check boxes indicating reason(s) for submitting application.
- Complete Section [I] – [Employer] Verification [in the lower right corner] of the form.
 - [Employer] must complete this section for all new enrollments, coverage changes and terminations.
 - [Employer] must sign and date the Enrollment/Change Request in order for it to be processed.

[Employee] – Complete Sections [B-H]**Section B – [Employee] 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).]
- Select only an option offered by your [employer].

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 post-secondary student, you must attach a current course schedule or a letter from the school or its authorized representative confirming full-time student status. If dependent is disabled and being continued beyond the limiting age, attach proof of disability]
- If you or your dependent(s) have other Health [or Rx drug] coverage, check off the “Yes” box(es) and complete Section [F] – Other/Previous Insurance.
- [From the appropriate provider directory, locate the [6-digit] office ID number for the primary care physician, ob/gyn (if applicable), and/or dentist (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. Exceptions: For Small Employer Group coverage, this section must be completed only by persons enrolling in group coverage in a group of 2 – 5 [employees] and by late entrants.]

Section [F] Other / Previous Insurance

- Complete this section for all new enrollments or coverage changes. Coverage includes group coverage, governmental coverage, a church plan or Medicare.

Section [G] – Dependent Information

- Complete this section for all new enrollments or coverage changes

Section [H] – [Employee] Signature:

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

Section [I] – [Employer] Verification:

NJ-HINT-Group

[Internal Carrier Form Number]

- [Employer] must complete this section for all new enrollments, coverage changes and terminations.
- [Employer] must sign and date the Enrollment/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] 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] [plan or group 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 plan documents. My employer is hereby authorized to withhold payments from my wages, as appropriate.

Misrepresentation

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

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 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. "Add Domestic Partner" if coverage offered.

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 Omit one or more "Add/Change Office ID Numbers" options if carrier does not offer such options.

⁸ The continuation billing options should be omitted if the carrier does not offer such options.

⁹ Re-letter Sections F – H accordingly if Section E Pre-Existing Conditions Statement is being omitted. Add e-mail address if option offered.

¹⁰ Insert carrier plan options and deductibles, coinsurance or copayment options.

¹¹ 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.

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- ¹³ Omit "Primary Office ID Number" section if the plan does not require the selection of a Primary Care Physician.
 - ¹⁴ Omit "Current Patient" section if the carrier does not require.
 - ¹⁵ Omit "Rx Drug" section and corresponding question in Section F if carrier does not require.
 - ¹⁶ Omit "Ob/Gyn Office ID Number" section if the plan does not require the selection of an Ob/Gyn Physician.
 - ¹⁷ Omit "Dentist Office ID Number" section if the plan does not require the selection of a Dentist.
 - ¹⁸ 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 enrollment form. Re-letter succeeding sections.
 - ¹⁹ Carrier's pre-existing conditions period. For plans other than small employer plans, insert the pre-existing conditions periods that are contained in non-small employer plans. For small employer plans, the period is six months.
 - ²⁰ If the carrier does not want the Certificate of Creditable Coverage to be supplied with the Enrollment/Change Request, omit the directions to supply it.
 - ²¹ If the carrier refers to the "Agreement" using another term such as "Plan," "Contract," "Policy" or some similar term, replace the term "Agreement" with such other term throughout the document.
 - ²² If the carrier refers to the "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.
 - ²³ Insert carrier's phone number.
 - ²⁴ Carrier should insert the procedure to be followed to allow the applicant to secure coverage before the actual ID card is issued.
 - ²⁵ Available for carriers that use an internal number in addition to the identifying form number.

NJ-HINT-Group

[Internal Carrier Form Number]

New Rule, R.2004 d.460, effective December 20, 2004.
See: 36 N.J.R. 1282(a), 36 N.J.R. 5913(A).

Administrative correction.
See: 37 N.J.R. 530(b).

NJ-HINT-Individual

[Internal Carrier Form 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 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 without a break in coverage of 63 or more days? Yes No

If yes identify the individual(s)

Were any of the individuals' most recent prior creditable coverage under a group health plan, governmental plan, church plan, or health insurance coverage offered in connection with any such plan? Yes No

If yes identify the individual(s)

[Please include a Certificate of Creditable Coverage, if available.]¹³

[I] Payment Information

Monthly Quarterly Semi-Annually

Payment Instrument: Check Money Order Credit Card Type/Name on Credit Card _____ No. _____ Exp. Date _____

Name on Card _____ Automatic Bank Draft (attach voided check)¹⁴

NJ-HINT-Individual

[Internal Carrier Form Number]

[J] **[Applicant] Signature** *If you have questions concerning the benefits and services provided by or excluded under this [Policy]¹⁵ contact a [Member Services]¹⁶ representative at [phone number]¹⁷ 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.]¹⁸

[K]. Broker/General Agent Information

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

General Agent: _____ Agent ID #: _____¹⁹

[Internal Carrier Form Number]²⁰

NJ-HINT-Individual

[Internal Carrier Form Number]

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 post-secondary student, you must attach a current course schedule or a letter from the school or its authorized representative confirming full-time student status. 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.

NJ-HINT-Individual

[Internal Carrier Form Number]

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.

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. "Add Domestic Partner" if coverage offered.

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. Add e-mail address if option offered.

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 If the carrier does not want the Certificate of Credible Coverage to be supplied with the Application/Change Request, omit the directions to supply it.

¹⁴ Omit those payment options or modes that are unavailable.

¹⁵ 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.

¹⁶ If the carrier refers to the "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.

¹⁷ Insert carrier's phone number.

¹⁸ Carrier should insert the procedure to be followed to allow the applicant to secure coverage before the actual ID card is issued.

¹⁹ 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.

²⁰ Available for carriers that use an internal number in addition to the identifying form number.

New Rule, R.2004 d.460, effective December 20, 2004.
See: 36 N.J.R. 1282(a), 36 N.J.R. 5913(a).

SUBCHAPTER 4. ORGANIZED DELIVERY SYSTEMS

Authority

N.J.S.A. 17:1-8.1, 17:1-15e and 17:48H-1 et seq.

Source and Effective Date

R.2002 d.336, effective October 21, 2002.
See: 34 N.J.R. 20(a), 34 N.J.R. 3607(a).

11:22-4.1 Purpose and scope

(a) This subchapter sets forth the filing and requirements for an entity to be licensed as an organized delivery system pursuant to N.J.S.A. 17:48H-1 et seq.

(b) This subchapter applies to any entity seeking to become licensed as an organized delivery system pursuant to N.J.S.A. 17:48H-1 et seq.; or an existing organized delivery system required to obtain a license to operate pursuant to N.J.S.A. 17:48H-11. A non-exhaustive list of examples of entities and arrangements that are subject to these rules is set forth in Exhibit B in the Appendix to this subchapter, incorporated herein by reference.

11:22-4.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

“Affiliate” means a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the organized delivery system.

“Capitation” means a fixed per member, per month, payment or percentage of premium payment for which the provider assumes the risk for the cost of contracted services without regard to the type, value or frequency of the services provided.

“Carrier” means an insurer authorized to transact the business of health insurance as defined at N.J.S.A. 17B:17-4, a hospital service corporation authorized to transact business in accordance with N.J.S.A. 17:48-1 et seq., a medical service corporation authorized to transact business in accordance with N.J.S.A. 17:48A-1 et seq., a health service corporation authorized to transact business in accordance with N.J.S.A. 17:48E-1 et seq. or a health maintenance organization authorized to transact business pursuant to N.J.S.A. 26:2J-1 et seq.

“Certified organized delivery system” means an organized delivery system that is compensated on a basis which does

not entail the assumption of more than de minimis financial risk by the organized delivery system and that is certified by the DHSS in accordance with N.J.S.A. 17:48H-1 et seq.

“Commissioner” means the Commissioner of the New Jersey Department of Banking and Insurance.

“Comprehensive health care services” means the basic benefits provided under a health benefits plan, including medical and surgical services provided by licensed health care providers who may include, but are not limited to, family physicians, internists, cardiologists, psychiatrists, rheumatologists, dermatologists, orthopedists, obstetricians, gynecologists, neurologists, endocrinologists, radiologists, nephrologists, emergency services physicians, ophthalmologists, pediatricians, pathologists, general surgeons, osteopathic physicians, physical therapists and chiropractors. Basic benefits may also include inpatient or outpatient services rendered at a licensed hospital, covered services performed at an ambulatory surgical facility and ambulance services.

“Consumer Price Index” means the medical component of the Consumer Price Index for all Urban Consumers, as reported by the United States Department of Labor, shown as the average index for New York-Northern New Jersey-Long Island region and the Philadelphia-Wilmington-Trenton-region combined as published by the Commissioner in the New Jersey Register.

“Department” means the New Jersey Department of Banking and Insurance.

“DHSS” means the New Jersey Department of Health and Senior Services.

“Financial risk” means exposure to financial loss that is attributable to the liability of an organized delivery system for the payment of claims or other losses arising from covered benefits for treatment or health care services other than those performed directly by the person or organized delivery system liable for payment, including a loss sharing arrangement. A payment method wherein a provider accepts reimbursement in the form of a capitation payment for which it undertakes to provide health care services on a prepayment basis shall not per se be considered financial risk. A financial risk shall exist if, under an agreement between the organized delivery system and the carrier, the financial obligations of the organized delivery system for payment of benefits or for providing treatment or health care services does or potentially may exceed any payments that may be received from the carrier. Financial obligation shall include the attendant administrative costs related to providing the treatment or services.

“Health benefits plan” means a benefits plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this State by or through a carrier. Health benefits plan includes, but is not limited to, Medicare supplement coverage and

risk contracts to the extent not otherwise prohibited by Federal law. For the purposes of this subchapter, health benefits plan shall not include the following plans, policies or contracts: accident only, credit, disability, long-term care, CHAMPUS supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to N.J.S.A. 39:6A-1 et seq. or hospital confinement indemnity coverage.