During the past 6 months have you, or any dependent to be covered had, or been diagnosed as having:

		Yes	No
1. a.	Alcoholism, 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 or Condition or 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 Pregnancy Exist Expected Due Date:	—	—

2. During the past 6 months, have you or any dependent to be covered:

		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 medications?	—	—

Please give details for any "Yes" answers to any parts of questions 1 or 2. Attach a separate sheet if more space is needed for answers. The separate sheet should be signed and dated.

Question # and Letter	Name of Person	Condition	Duration of Symptoms, Treatment Degree of Recovery	Date	Name and Address of Hospitals, Practitioners

]

5.**PROVIDER SECTION**

	FULL NAME OF PRIMARY CARE PHYSICIAN AND OFFICE ID NO	HEALTH CENTER* (If applicable)	[GYNECOLOGIST OFFICE NO.]	ESTABLISHED PATIENT	PRIMARY CARE PHYSICIAN CHANGE	HEALTH CENTER CHANGE
1 Applicant			[ ] Yes [ ] No		[ ]	[ ]
2 Spouse			[ ] Yes [ ] No		[ ]	[ ]
3 Child			[ ] Yes [ ] No		[ ]	[ ]
4 Child			[ ] Yes [ ] No		[ ]	[ ]
5 Child			[ ] Yes [ ] No		[ ]	[ ]

[Statewide Physician Network [ ] Health Carrier [ ]]

* When selecting Health Center option, please also select a Primary Care Physician from among the Health Center doctors.

[5.][6.] **AUTHORIZATION AND CERTIFICATION**

I hereby apply to (carrier) for coverage for any eligible dependents listed above and myself.

[I have been offered the opportunity to add the following coverage(s) to the New Jersey Individual Health Benefits Plan and I accept or reject, as shown below: Coverage for treatment of cancer by dose intensive chemotherapy/autologous bone marrow transplants and peripheral blood stem cell transplants pursuant to New Jersey Assembly Bill 1997, P.L. 1995 c. 100. [ ] Accept [ ] Reject]

I understand that for the 12 months following the effective date of this [policy] [contract], benefits are not provided for health care services received for (a) conditions for which medical advice, diagnosis, care or treatment was recommended or received during the last 6 months, (b) conditions for which during the last 6 months there were symptoms which would cause a prudent person to seek medical advice, diagnosis, care, or treatment, or (c) pregnancy existing on the effective date of this [policy] [contract]. (Note: This limitation may not apply if the eligible person transfers from another health benefits plan.)

[[Unless I request otherwise in writing,] I understand that by signing below when I file a claim, (carrier) may pay the health care benefits directly to the provider instead of to me.]

I agree that: (a) any physician, hospital or other provider is authorized to provide to (carrier or its assignee) information about any eligible person's medical history; and (b) any company or person having information concerning other health care coverage in force, or available to, any eligible person may give such information to (carrier or its assignee).

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

I state that: (a) I am a resident of New Jersey [and reside within the (carrier) service area (if applicable)], (b) the information given on this application is complete to the best of my knowledge and belief and (c) that (carrier) will rely on this information to determine eligibility. I understand that if I omit or falsify any statement in this application (carrier) can cancel this contract as of the original effective date.

Applicant's Signature: _____ Date Signed: _____
Spouse' Signature: _____ Date Signed: _____
Preparer's Signature: _____ DOI License # _____ Date Signed: _____
NOTE TO ALL APPLICANTS: If we accept your application, a copy of the application will be sent to you. Attach the copy to your [contract] [policy]. It becomes part of your contract with us.

[6.][7.] **INCOME HOUSEHOLD**

Completion of this section is optional. The information will be used for statistical purposes only, in a way that will not identify you personally. This information will not affect your application, acceptance of coverage.

[ ] under $20,000 [ ] $20–$29,999 [ ] $30–$39,999 [ ] $40–$49,999
[ ] $50–$59,999 [ ] $60,000 and above

For [Carrier] [Plan] Use Only	[Effective Date]	[Billing]	[Coverage Code]	[Type]	[Pre-Ex]	[Continuous Coverage]	[Transcode]	[ ]

Amended by R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).
See: 26 N.J.R. 4884(a), 27 N.J.R. 565(a).

Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).

EXHIBIT H

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB 0938 0008

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

PICA

MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

PATIENT AND INSURED INFORMATION

2 PATIENT'S NAME (Last Name, First Name, Middle Initial)

3 PATIENT'S BIRTH DATE MM DD YY | SEX M F

4 INSURED'S NAME (Last Name, First Name, Middle Initial)

5 PATIENT'S ADDRESS (No., Street)

6 PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7 INSURED'S ADDRESS (No., Street)

CITY | STATE

8 PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10 IS PATIENT'S CONDITION RELATED TO:

11 INSURED'S POLICY GROUP OR FECA NUMBER

a OTHER INSURED'S POLICY OR GROUP NUMBER

a EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO

a INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b AUTO ACCIDENT? YES | NO | PLACE (State)

b EMPLOYER'S NAME OR SCHOOL NAME

c EMPLOYER'S NAME OR SCHOOL NAME

c OTHER ACCIDENT? YES | NO

c INSURANCE PLAN NAME OR PROGRAM NAME

d INSURANCE PLAN NAME OR PROGRAM NAME

10d RESERVED FOR LOCAL USE

d IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14 DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY

15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a I.D. NUMBER OF REFERRING PHYSICIAN

18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19 RESERVED FOR LOCAL USE

20 OUTSIDE LAB? YES | NO $ CHARGES

21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)

1 2 3 4

22 MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23 PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25 FEDERAL TAX I.D. NUMBER SSN EIN

26 PATIENT'S ACCOUNT NO.

27 ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28 TOTAL CHARGE $

29 AMOUNT PAID $

30 BALANCE DUE $

31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33 PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

ST11798 HCFA-1500 (LASER) 12/90 (OCR BC)

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8-88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

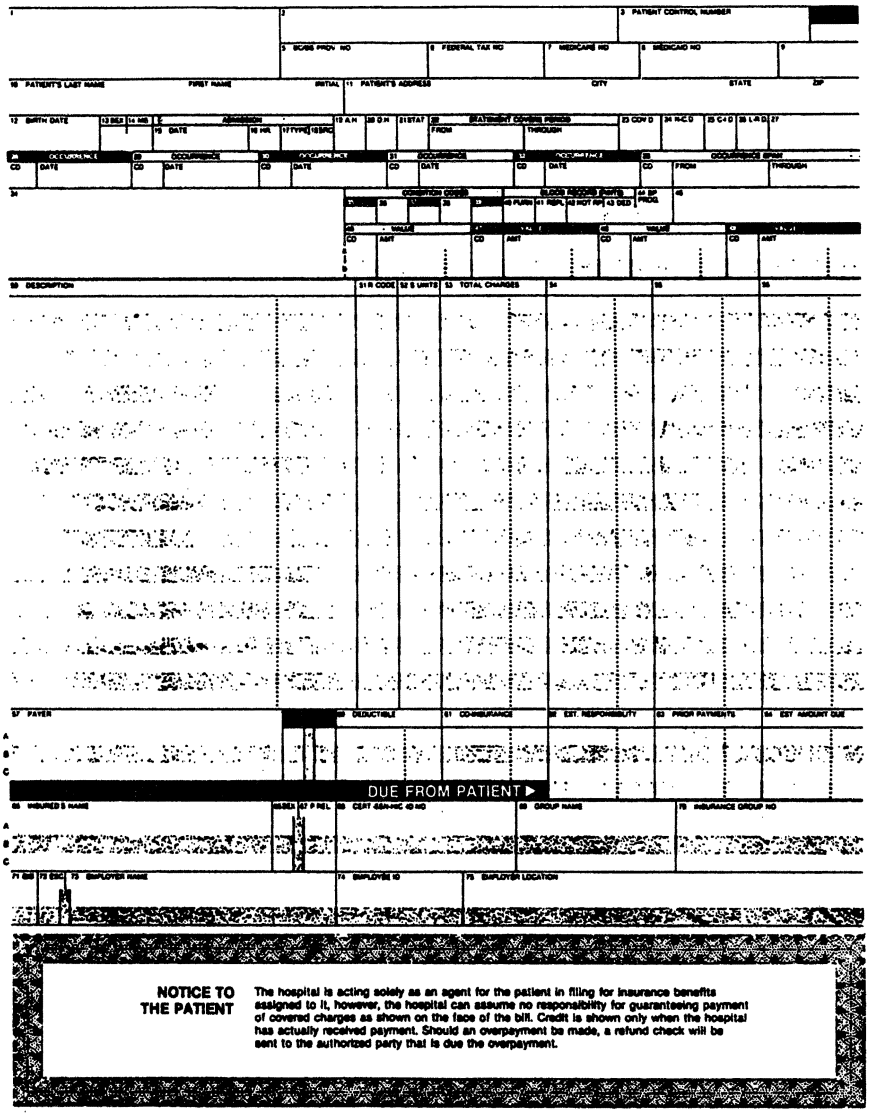

EXHIBIT J

Loss Ratio Report Form New Jersey Individual Health Coverage Program

Reporting Year 19____, for the Preceding Calendar Year Ending December 31, ____

Name of Carrier _____NAIC # _____

Address _____

_____

Carriers shall complete and file a separate Report Form for each affiliate. Note: Read the corresponding regulation, N.J.A.C. 11:20–7, before you complete this Report.

A. Net Earned Premium for Standard Health Benefits Plans $ _____

B. Total Losses Incurred (1 - 2 - 3 + 4 + 5 + 6) = $ _____

1. Claims paid during the preceding calendar year regardless of the year incurred; $ _____
2. Residual reserve set on June 30 of the preceding calendar year for claims incurred prior to January 1 of the preceding calendar year; _____
3. Claims paid from January 1 through June 30 of the preceding calendar year for claims incurred prior to January 1 of the preceding calendar year as reported in the preceding calendar year's loss ratio report; _____
4. Claims paid from January 1 through June 30 of the reporting year for claims incurred prior to January 1 of the reporting year; _____
5. Residual reserve for claims incurred prior to January 1 of the reporting year, not paid as of June 30 of the reporting year; _____
6. Pro rata share of the reimbursable net paid loss assessment paid by the carrier during the preceding calendar year pursuant to N.J.A.C. 11:20–2.17; [i × (ii ÷ iii)] = _____
   i. Total net paid loss assessment _____
   ii. Net earned premium for standard health benefits plans _____
   iii. Net earned premiums for all health benefits plans _____

C. Loss Ratio (B ÷ A) = ____% (if less than 75%, fill out D and E below)

D. Amount entered on line B ÷ .75 = _____

E. Amount to be refunded to policy or contract holders (A-D) = _____

If the amount entered on line C is less than 75%, you must attach to this Report a refund plan that conforms with N.J.A.C. 11:20–7.5. Please submit this form and a refund plan to the address listed in N.J.A.C. 11:20–2.1(h).

I certify that the above information is accurate, complete and has been prepared in accordance with N.J.S.A. 17B:27A–9e(1) and (2) and N.J.A.C. 11:20–7.

_____
Actuary's Signature

_____
Actuary's Name (Please print clearly)

_____
Title Date

_____
Telephone Number

Amended by R.1996 d.193, effective April 15, 1996.
See: 27 N.J.R. 4493(a), 28 N.J.R. 2008(a).

EXHIBIT K

New Jersey Individual Health Coverage Program

Carrier Market Share and Net Paid Loss Report

This Report must be completed in accordance with the provisions of N.J.A.C. 11:20-8, and certified to by the Chief Financial Officer or other duly authorized officer of the Carrier. In 1993, Reports must be completed and returned on or before June 28, 1993. Thereafter, Reports must be completed and returned on or before March 1 annually. Completed Reports must be returned to the Executive Director at the address listed in N.J.A.C. 11:20-2.1(h).

Part A. Carrier Information

1. Carrier's Name: _____
2. Carrier's NAIC Number (including Group): _____
3. Is the specifically-named Carrier an affiliated Carrier?
   ___Yes ___No.
   a. If Yes, is this Report the combined Report for all Affiliated Carriers, or for the specifically-named Carrier?
      ___All Affiliated Carriers' combined Report
      ___Specifically-named Carrier's separate Report
   b. If for all Affiliated Carriers, indicate the number of specifically-named Carrier Reports attached to this combined Report. _____

Part B. Personal Respondent Information

1. Name: _____
2. Title: _____
3. Telephone No: _____ Facsimile No: _____

Part C. Calendar Year Information for _____ (year)

1. Net earned premium for all group and individual health benefits plans: $_____
2. Number of non-group persons enrolled by the Carrier:
   a. Community rated and modified community rated persons _____
   b. Community rated conversion policy persons _____
   c. Medicare cost and risk persons _____
   d. Medicaid recipients _____
   e. HealthStart Plus recipients _____
   Non-group Total _____
3. Net paid loss report for Individual Health Benefits Plans:
   a. PREMIUM EARNED
      Community rated and modified community rated $
   b. CLAIMS PAID (-)
      Community rated and modified community rated $
   c. EXPENSES (-)
      Community rated and modified community rated $
   d. SUBSIDIES (+)
      (BCBSNJ only; 1992 only)
   e. NET INVESTMENT INCOME (+)
      Community rated and modified community rated $
   f. NET PAID GAIN/(LOSS)
      Community rated and modified community rated $_____
   g. REIMBURSEMENT SOUGHT $_____
      (For 1992: Limited to the Lesser of $10,000,000 or 50% of the Net Paid Loss)

Part D. Certification

I certify that the information provided in this Report is accurate and complete, and has been prepared in accordance with the provision of N.J.A.C. 11:20–8.

_____ _____ _____
Signature Title Date

EXHIBIT L

Part 1

Carrier Name _____ Name of Person Completing Report _____

Year Ending _____ Telephone Number _____

Fax Number _____

Enrollment Status Report — Open Enrolled, Community Rated Individual Plans

Quarterly Statistics

Health Benefits Plan	Issued Prior to August 1, 1993	Plan A		Plan B		Plan C		Plan D		Plan E		HMO Plan	Total
		Indemnity	PPO/POS	Indemnity	PPO/POS	Indemnity	PPO/POS	Indemnity	PPO/POS	Indemnity	PPO/POS		
A. Report by Subscriber Contract													
I. Number of Contracts Inforce Beginning of Period													
II. Number Issued and Conversions Issued in Period													
Total Number of New Contracts													
Contracts by Employment Status													
Number Employed													
Number Unemployed													
Number Unknown													
Contracts by Replacement Status													
Number Previously Insured													
Number Previously Uninsured													
Number Unknown													
III. Number of Contract Lapses in Period													
IV. Number of Contracts Inforce End of Period (I. + II. - III.)													
B. Report by Persons Insured (End of Period)													
I. Number Insured Beginning of Period													
II. Number of New Insureds During Period													
III. Number of Insureds Lapsed During Period													
IV. Number Insured End of Period (I. + II. - III.)													
C. Report of Contracts by Rating Category (End of Period)													
Number of Single Subscriber Contracts													
Number of Husband and Wife Subscriber Contracts													
Number of Parent and Children Contracts													
Number of Family Contracts													
D. Report of Contracts by Deductible/Copayment Option (End of Per.)													
Number of Subscriber Contracts with $150 or $250 Deduct or $10 Copay													
Number of Subscriber Contracts with $500 Deduct or $15 Copay													
Number of Subscriber Contracts with $1000 Deduct or $20 Copay													

Part 2

Annual Report Page 1

Carrier Name _____ Name of Person Completing Report _____

Year Ending _____ Telephone Number _____

Fax Number _____

Enrollment Status Report — Open Enrolled, Community Rated Individual Plans

Annual Statistics

Health Benefits Plan		Plan A		Plan B		Plan C		Plan D		Plan E		HMO Plan	Total
		Indemnity	PPO/POS	Indemnity	PPO/POS	Indemnity	PPO/POS	Indemnity	PPO/POS	Indemnity	PPO/POS		
A. Report of Contracts by Zip Code Categories													
Number of Subscriber Contracts in Zip Code Areas 070 073													
Zip Code Areas 074 075													
Zip Code Areas 076													
Zip Code Areas 077													
Zip Code Areas 078													
Zip Code Areas 079													
Zip Code Areas 080 084													
Zip Code Areas 085													
Zip Code Areas 086													
Zip Code Areas 087													
Zip Code Areas 088 089													
Total Subscribers													
B. Report of Covered Persons by Age and Sex													
Number of Male Covered Persons Insured End of Period													
Age 0 to 20													
20 to 30													
30 to 40													
40 to 50													
50 to 60													
60 to 65													
65 to 70													
70 & Over													
Number of Female Covered Persons Insured End of Period													
Age 0 to 20													
20 to 30													
30 to 40													
40 to 50													
50 to 60													
60 to 65													
65 to 70													
70 & Over													
Total Covered Persons End of Period													

Annual Report Page 2

C. Report of Salary Data															
Number of Subscriber Contracts															
Salary Under $10,000															
$10 to $20,000															
$20 to $30,000															
$30 to $40,000															
$40 to $50,000															
$50 to $60,000															
$60,000 & Over															
Total Subscribers															