UNIFORM BILL: **NOTICE: ANYONE WHO MISREPRESENTS OR FALSIFIES ESSENTIAL INFORMATION REQUESTED BY THIS FORM MAY UPON CONVICTION BE SUBJECT TO FINE AND IMPRISONMENT UNDER FEDERAL AND OR STATE LAW.**

Certifications relevant to the Bill and Information Shown on the Face Hereof: Signatures on the face hereof incorporate the following certifications or verifications where pertinent to this Bill:

1. If third party benefits are indicated as being assigned or in participation status, on the face thereof, appropriate assignments by the insured/beneficiary and signature of patient or parent or legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the particular terms of the release forms that were executed by the patient or the patient's legal representative. The hospital agrees to save harmless, indemnify and defend any insurer who makes payment in reliance upon this certification, from and against any claim to the insurance proceeds when in fact no valid assignment of benefits to the hospital was made.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Christian Science Sanitoriums, verifications and if necessary re-verifications of the patient's need for sanitorium services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal law and regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 thru 1086, 32 CFR 199) and, any other applicable contract regulations, is on file.
6. This claim, to the best of my knowledge, is correct and complete and is in conformance with the Civil Rights Act of 1964 as amended. Records adequately disclosing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare purposes:

   If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his medical expenses and he wants information about his claim released to them upon their request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare authorizes any holder of medical and other information to release to Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, workers' compensation, or other insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes:

   This is to certify that the foregoing information is true, accurate, and complete.

   I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws.
9. For CHAMPUS purposes:

   This is to certify that:

   (a) the information submitted as a part of this claim is true, accurate and complete, and, the services shown on this form were medically indicated and necessary for the health of the patient;

   (b) the patient has represented that by a reported residential address outside a military treatment center catchment area he or she does not live within the catchment area of a U.S. military or U.S. Public Health Service medical facility, or if the patient resides within a catchment area of such a facility, a copy of a Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;

   (c) the patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverages, and that all such coverages are identified on the face of the claim except those that are exclusively supplemental payments to CHAMPUS-determined benefits;

   (d) the amount billed to CHAMPUS has been billed after all such coverages have been billed and paid, excluding Medicaid, and the amount billed to CHAMPUS is that remaining claimed against CHAMPUS benefits;

   (e) the beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and

   (f) any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent but excluding contract surgeons or other personnel employed by the Uniformed Services through personal service contracts. Similarly, members of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.

   (g) based on the Consolidated Omnibus Budget Reconciliation Act of 1986, all providers participating in Medicare must also participate in CHAMPUS for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.

   (h) if CHAMPUS benefits are to be paid in a participating status, I agree to submit this claim to the appropriate CHAMPUS claims processor as a participating provider. I agree to accept the CHAMPUS-determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. I will accept the CHAMPUS-determined reasonable charge even if it is less than the billed amount, and also agree to accept the amount paid by CHAMPUS, combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. I will make no attempt to collect from the patient (or his or her parent or guardian) amounts over the CHAMPUS-determined reasonable charge. CHAMPUS will make any benefits payable directly to me, if I submit this claim as a participating provider.

ESTIMATED CONTRACT BENEFITS

Repeal and New Rule, R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).

EXHIBIT M

Carrier:
Group Medical Claims
PO Box XXXXX
Anywhere, New Jersey XXXXX

GE 0094
Annual Family Profile
and Claim Notice

Send this form once each calendar year to the address above with your first claim of the year. If any information changes, send a new one. If you have questions about claims or need forms, call XXX-XXX-XXXX

Employer name	Employer phone number	Plan/Policy Number

Check one ☐ Active employee ☐ Retired employee ☐ Continued individual

Employee information

Name	Date of birth	Social Security Number

Address	City	State	ZIP	Home phone number

Do you have another employer? ☐Yes ☐No	If "Yes," please give name of other employer	Other employer's phone number

Are you covered by another group plan? ☐Yes ☐No	If "Yes," please give name of carrier	Plan number	Other carrier's phone number

Spouse information

Name	Date of birth	Social Security Number

Name and address of spouse's employer	Phone number of spouse's employer

Is spouse covered by another group plan? ☐Yes ☐No	If "Yes," please give name of other carrier	Plan number	Other carrier's phone number

Dependent children information

Name	Date of birth ☐Male ☐Female	Social Security No.	Relation to employee	Handicapped ☐Yes ☐No

List any additional dependent children on a separate page and attach it to this form.
If any child is over the limiting age and a full-time student, please give the information requested below.

Name	Name of school	Address of school

If any child is covered by another group plan, please give the information requested below.

Name	Insured person	Name of carrier	Plan number

I authorize any provider, insurer, or other organization to release any information regarding the medical history, treatment, or benefits payable for this claim to the plan administrator or its authorized agent for the purpose of determining benefits payable.

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, may be committing a criminal act.

Signature of employee _____ Signature of patient if other than minor child _____ Date _____

SEH-FP-7/93

EXHIBIT N

[Carrier]

APPLICATION FOR A SMALL EMPLOYER HEALTH BENEFITS POLICY

Please print or type
[ ] New Policy [ ] Change in Policy
Policy number: ([Carrier] Use Only)
Requested Effective Date: _____

SECTION I: POLICYHOLDER INFORMATION

1. Policy holder (full legal name of company): _____
2. Tax Identification Number: _____
3. Main Address: _____

Street *City* *State* *Zip*

Mailing Address: _____

Street *City* *State* *Zip*

Telephone: ( ) _____ Facsimile: ( ) _____

4. Name of Correspondent: _____ Title: _____
5. Type of organization: [ ] Corporation [ ] Partnership [ ] Proprietorship [ ] Other (explain): _____
6. Nature of business (specify): _____ SIC Code _____
7. Number of eligible employees in your company: _____
   Refer to the New Jersey Small Employer Certification for the definition of an eligible employee
8. Number of eligible employees to be insured: _____
9. Class or classes to be excluded: _____
10. Insurance Requested For: [ ] Employees Only [ ] Employees and Dependents
11. Are you subject to the requirements of COBRA? [ ] Yes [ ] No
12. Waiting period before employees become insured: (may not exceed 6 months)
    Present employees: _____ New or Rehired Employees _____
13. What percentage of the premium will the employer pay? _____
14. Deposit $ _____

Premium Paid [ ] Monthly [ ] Quarterly [[ ] Automatic checking withdrawal]
Premium will be due as of the effective date. The premium for the first month of coverage must be attached.
Affiliates, subsidiaries or branches (Must be included for purposes of participation)

Legal Name & Location	No. eligible ees in this company	No. eligible ees to be insured

SECTION II: SPECIFICATIONS FOR COVERAGE

[HEALTH BENEFITS
[ ] Wraparound (Hospital Base Plan _____ days)
Plan: [ ] A [ ] B [ ] C [ ] D [ ] E [ ] HMO [ ] HMO POS [ ] Dual Contract POS
Deductible (Options for plans B, C and D only): [ ] $250 [ ] $500 [ ] $1,000
High Deductible Options: $_____
Co-Payment (Options for HMO Plans Only) [ ] $5 [ ] $10 [ ] $15 [ ] $20
Managed Care Delivery System: [ ] PPO [ ] POS [ ] None
PRESCRIPTION DRUG BENEFITS
Program Type: [ ] Card [ ] Mail Order [ ] Card/Mail Order
MENTAL AND NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFITS
Co-Payment Option [ ] $5 [ ] $10 [ ] $15 [ ] $20
NON-STANDARD OPTIONAL BENEFIT RIDERS]

SECTION III: ALL QUESTIONS MUST BE ANSWERED

1. Is there any insurance plan:
   - now inforce and to be continued? [ ] Yes [ ] No
   - currently being applied for? [ ] Yes [ ] No

   If "Yes" give a description of the plan(s) and name of insurance carrier(s)_____
2. Name of present or prior group carrier_____
   Effective date of prior coverage: _____ Cancellation/termination date: _____
   Is the coverage applied for in this application replacing other group insurance [ ] Yes [ ] No
   If "Yes", give reason _____
   Plan being replaced: [ ] A [ ] B [ ] C [ ] D [ ] E [ ] HMO [ ] HMO POS [ ] Dual Contract POS [ ] Other _____
3. Has your firm been uninsured for 3 or more months prior to application? [ ] Yes [ ] No
4. What forms of insurance are now or were in force? [ ] Health Benefits [ ] Prescription Drugs (Attach copies of Booklet/Certificate and most recent Billing Statement)
5. Are extended benefits provided in case of termination of health benefits? [ ] Yes [ ] No
6. To the best of your knowledge are there any current or former employees or their eligible dependents whose health insurance is being continued? [ ] Yes [ ] No

Please provide the following information for each current/former employee or dependent on health continuations.

Name of Employee/Dependent	Date of Birth	Type of Continuation State/Federal/ Extended Benefits	Reason for Termination Disability/Other	Continuation Dates Start	Continuation Dates End

If additional space is needed, attach a separate sheet, signed and dated.

7. To the best of your knowledge:
   a. Are any employees or dependents presently incapacitated? [ ] Yes [ ] No
   b. Are any dependent children incapable of self-support due to a physical or mental disability? [ ] Yes [ ] No

Additional space to explain if items 1, 2 or 3 were answered "Yes". Refer to the question number, and give details including names, where appropriate.

SECTION IV: AGENT/PRODUCER INFORMATION

[To be supplied by Carrier and limited in scope to information concerning the agent/broker]

SECTION V: SIGNATURE

[It is understood that except as provided under applicable regulations, no individual shall become insured while not actively at work on a full-time basis, and only full-time employees are eligible. A full-time employee is one who regularly works at least 25 hours per week at his employer's place of business.] It is further understood that no agent has power on behalf of [Carrier] to make or modify any request or application for insurance or to bind [Carrier] by making any promise or representation or by giving or receiving any information.
It is further understood that no insurance will be effective unless and until the application is accepted in writing by [Carrier]. [Final rates will be based on enrollment data as of the Policy effective date.] No contract of insurance is to be implied in any way on the basis of the completion and/or submission of this application.
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
Dated at _____ on _____

Print name of Officer, Partner or Proprietor

Signature of Officer, Partner or Proprietor

Witness to Signature

Note: If there are any modifications to the statements and answers given in this application (i.e. crossed out, whited-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.

EXPLANATION OF BRACKETS AND TEXT
APPLICATION FOR A SMALL EMPLOYER HEALTH BENEFITS POLICY

1. The terms Policyholder and Policy may be replaced with Contractholder or Planholder and Contract or Plan, as appropriate.
2. The terms insurance and insured may be replaced with coverage and covered, as appropriate.
3. The reference to Automatic Checking Withdrawal may be deleted if Carrier does not offer such options.
4. The text of the Health Benefits section may vary to accommodate the options a Carrier will offer, including optional benefit riders. For example, if a Carrier does not offer HMO plans, such text may be deleted.
5. Agent/Producer Information may be consistent with a Carrier's usual procedures for securing data regarding the agent/producer for the purpose of commission payments.
6. If benefits are to be issued through a Multiple Employer Trust, a Carrier may include text which specifies that the employer is requesting participation in a Trust.
7. If a Carrier provided coverage to a small employer's employees working fewer than 25 hours per week and/or retirees under a health benefits plan issued prior to January 1, 1994, and such Carrier elects to continue to cover part-time employees and/or retirees after January 1, 1994, under the terms and conditions outlined in N.J.A.C. 11:21-7.3(e) and (f), the text of the first 2 sentences of the Signature section may be adjusted to reflect the expanded eligibility.

Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).

EXHIBIT O

NEW JERSEY SMALL EMPLOYER CERTIFICATION

For a policy of Group Health Benefits Insurance

Employer Name Group Policy No

Address Street City State Zip

EMPLOYEE CENSUS INFORMATION
Please include the following persons in the following list:
a. employees, owners, partners, officers, and independent contractors who are actively working for the employer on a regular basis and are paid by the employer on a regular basis, whether or not they are eligible to be covered under the policy.
b. employees, owners, partners, officers, and independent contractors who are not working, but who are currently covered under the employer's health benefits plan for reasons such as continuation of coverage or total disability.
Please use the following letters to indicate Status:

F: Full-time employee who works 25 or more hours per week
P: Part-time employee who works less than 25 hours per week
T: Temporary employee
I: Independent Contractor
D: Totally Disabled employee
C: Continuee under state or federal law
U: Employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement

Name	Job Title	Date of Employment	Hours worked per week	Status	Work Location (State)	[Gender]	[Age]
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							

If additional space is needed, attach a separate sheet.

CERTIFICATION AS A SMALL EMPLOYER IN THE STATE OF NEW JERSEY IN ACCORDANCE WITH NEW JERSEY CH. 162

Group Health Benefits Policy Participation (All Questions Must Be Answered)

An Eligible Employee is one who works on a full-time basis with a normal work week of 25 or more hours. An employee who works less than 25 hours per week, on a temporary or substitute basis, or an employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement is not an eligible employee.

Total # Eligible Employees _____
Total # Eligible Employees applying/enrolling for health benefits coverage _____
Total # Eligible Employees waiving health benefits coverage under this policy with coverage under a spouse's coverage, other than individual coverage; or under any Health Benefits Plan offered by the employer _____
Total # Eligible Employees waiving health benefits coverage under this policy without coverage under a spouse's coverage, other than individual coverage; or under any Health Benefits Plan offered by employer _____
[Is your firm subject to Working Aged Provisions (TEFRA/DEFRA)? [ ] Yes [ ] No]
[Is your firm subject to the requirements of COBRA? [ ] Yes [ ] No]

CERTIFICATION

(Please sign and date appropriate section indicating whether or not you meet the definition of a small employer)

A Small Employer is any person, firm, corporation, partnership or association actively engaged in business who during at least fifty percent of its working days in the preceding CALENDAR YEAR/QUARTER, employed NO MORE THAN FORTY-NINE eligible employees and NO LESS THAN TWO eligible employees, the majority of whom were employed in the State of New Jersey. In determining the number of eligible employees, companies which are affiliated companies shall be considered one employer. State, county, or municipal bodies, agencies, boards, or departments are not considered Small Employers.

I certify that I qualify as a Small Employer in the State of New Jersey.

I certify that the information provided to [Carrier] is true and complete. I understand that if the above information is not complete or is not provided to [Carrier] in a timely manner, then health benefits coverage does not have to be offered or continued. I further understand that incomplete or untrue information may void health benefits coverage.

I understand that I and my employees may be subject to fines if an employee who is a resident of New Jersey and is eligible for coverage under this group health benefits plan is enrolled in an individual health benefits plan issued on or after August 1, 1993.

Any person who knowingly files a statement of claim, application for insurance, enrollment form, or certification containing any false or misleading information, may be subject to criminal and civil penalties.

Signature of Officer, Partner or Owner Title Date

Print Name of Officer, Partner, or Owner

Signature of Witness Date

I Certify that I am not a Small Employer in the State of New Jersey, as defined above.

Signature of Officer, Partner or Owner Title Date

Print Name of Officer, Partner, or Owner

Signature of Witness Date

SEH-SEC-94-2

Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).

EXHIBIT Q

[Carrier]
SMALL GROUP EMPLOYER BENEFITS ENROLLMENT [AND CHANGE FORM] [AND PRE-EXISTING CONDITIONS STATEMENT]
Please print all information, using ink.
[Policyholder] (full legal name of company):_____ **(Policy) No:** _____
[Policyholder] Address:_____
Street **City** **State** **Zip Code**

SECTION I: EMPLOYEE INFORMATION

Name:_____
Last First Middle Initial
Home Address:_____
Street [Apt.] City [County] State Zip Code
[Telephone:_____ _____
Home Work
Best place to call during day: _____ Home _____ Work]
Occupation: _____ Title:_____
Date of Employment: _____ Hours worked per week:_____
Are you actively at work? _____ Yes _____ No If "No", explain: _____
Marital Status: _____ Single _____ Married _____ Widowed _____ Divorced
[Are you a resident of the state of New Jersey? _____ Yes _____ No
Do you maintain a residency in another state? _____ Yes _____ No
If "Yes", name the state _____
How much time do you spend there each year? _____]

[REASON FOR COMPLETION OF THIS FORM (please check all appropriate responses)

_____ I am an employee of an organization which is applying for coverage
_____ I am now eligible for coverage
_____ I had no previous coverage during the past 90 days
_____ I had previous coverage during the past 90 days.
Name of previous carrier _____ Plan Number:_____
Effective Date: _____ Termination Date:_____
_____ I previously refused/waived coverage
_____ I am enrolling for coverage during my employer's open enrollment period.
Open Enrollment Date: _____
_____ I am continuing under _____ Federal Law (COBRA) or _____ State Law
Qualifying Event: _____ Date Continuation began:_____
Continuation applies to: _____ Employee Only _____ Employee and Eligible Dependents
_____ I am continuing under a total disability extension (Attach proof of disability)
_____ I am terminating coverage for myself, and all dependents
_____ I am adding/deleting dependents
_____ Other (Specify): _____]

SECTION II: COVERAGE INFORMATION

1. Persons to be covered: _____ Employee Only _____ Employee & Child(ren)
_____ Employee & Spouse _____ Employee, Spouse & Child(ren)

2. Please provide all information for each person to be covered [or deleted].

Full Name (Last, First, Middle Initial)	Add[/Delete]	Sex	Social Security No.	Birthdate
Employee				
Spouse				
Child				
Child				
Child				
Child				

Attach a separate sheet to list additional children. [Attach proof if full time student. Attach proof of disability.]
[3. Do any of the dependents listed above live at an address other than the Home address given above?
____ Yes ____ No If "Yes", name the dependent(s) and provide the address(es)
_____
_____
Explain the circumstances_____
4. If any dependent's last name differs from yours, explain the circumstances
_____]
[5. Are any of the dependents listed above confined in a facility or at home, due to a medical reason?
____ Yes ____ No If "Yes", name the dependent(s), and the place and reason for confinement.
_____

[6] Indicate whether any person to be covered is enrolled under Medicare, Parts A and/or B.

	Part A	Part B	*Medicare ID #*
Employee	___ Yes ___ No	___ Yes ___ No	_____
Spouse	___ Yes ___ No	___ Yes ___ No	_____
Child (give name) _____	___ Yes ___ No	___ Yes ___ No	_____

[7] Which coverage have you selected to be primary in the event expenses are incurred as a result of an automobile related injury? _____ Auto _____ Medical

[[8] Are you, or any person to be covered eligible for other health coverage? (i.e. employer sponsored group coverage, Medicare, Medicaid) _____ Yes _____ No If "Yes", indicate the name(s) of the person(s), the name(s) of the carrier(s), the policy number(s) and the type(s) of coverage.

[9] Have you, or any dependent(s), as a [Carrier] health plan member, received care at any [Carrier] health care center? _____ Yes _____ No If "Yes", please indicate the medical record number in the space below.
If the name of you or your dependent(s) was different at the time of receiving care, please indicate.
(ex. maiden name)_____

[10] Are you replacing existing coverage? _____ Yes _____ No If "Yes", give the name and policy number of the replaced carrier, the effective and termination dates, and the name(s) of the persons covered by the policy.

[SECTION III: CHANGE INFORMATION

[Type of Activity

_____ Termination of Employee and Dependent Coverage [Please check reason(s) below]
Date of Termination _____
_____ Add/Remove Dependent
Reason _____
Date of Event _____
_____ New Telephone Number: (H) _____ (W)_____
_____ Change Contract Type from _____ to_____
_____ Change Name from _____ to_____
_____ Change of PCP, GYN Health Center (Circle which, state for whom and give new name)
_____ Withdrawal from Coverage
_____ Date of Event _____
_____ New Address:

Street [Apt.] City [County] State Zip Code]

[Termination Check Reason(s)

___ Deceased ___ Transferred to Other Coverage ___ Dissatisfied with Coverage
___ Ineligible ___ Moved Out of Area ___ Dissatisfied with Medical Care
___ Dissatisfied with Access
Other, please explain: _____
Remarks: _____]]

SECTION IV: PRE-EXISTING CONDITIONS STATEMENT

Note: 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 can only use the information to expedite the processing of claims. However, benefits, services or supplies for the treatment of a pre-existing condition may be limited for 180 days. This limitation of benefits, services and supplies applies only to employer groups with 2-5 employees and to late enrollees. Consult the agent or carrier for information on the waiving of this limitation under circumstances as provided under New Jersey Law.

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

		YES	NO
1. 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 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 of 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 Name	Condition	Duration of Symptoms, Treatment, Degree of Recovery	Date	Name & Address of Hospitals, Practitioners

[SECTION V: HEALTH CARE SELECTION

Full Name (Last, First, Middle Initial)	[Primary Care Physician]	[Health Care Center]	[GYN]
Employee			
Spouse			
Child			
Child			
Child			
Child			
[Plan Selection]			

SECTION VI: DECLARATION [AND] AUTHORIZATION [AND CONDITIONS OF ACCEPTANCE]

I hereby enroll for the group coverage to which I am or may be entitled. I authorize deductions from my pay for my share of the cost, if any.
I represent that to the best of my knowledge and belief, the statements and answers given above are true and complete. I understand that the information shall form the basis upon which I may be included for coverage under the group health benefits plan.
I understand that:

a) the coverage applied for will not take effect unless:
- after review of this Enrollment Form, [Carrier] accepts it;
- the first premium has been paid to [Carrier]; and
- I am either actively at work for full pay on a full time basis on the date coverage is to take effect, or subject to applicable regulations, I qualify under for a waiver of the active work requirement.

b) no person, except an officer of [Carrier] has authority to: determine whether [certificate/evidence of coverage] shall be issued based on this Enrollment Form; waive or modify any of the provisions of the Enrollment Form or any of the [Carrier's] requirements; to bind [Carrier] by any statement or promise pertaining to any [certificate/evidence of coverage] to be issued on the basis of this Enrollment Form; or accept any information or representation not contained in the written Enrollment Form.

c) the Employer is hereby designated my representative for the purpose of receiving contributions and remitting them to [Carrier].

[d) [Carrier] does not pay benefits for charges, or provide services or supplies related to a pre-existing condition until a person covered under the [policy/contract] has been continuously covered under the [policy/contract] 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: a) a 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 b) an ordinarily prudent person would have sought medical advice, care or treatment in the 6 months before coverage starts; or
- a pregnancy which exists on the date a person's coverage takes effect.]

[[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 state that I am a resident of New Jersey [and I reside within [Carrier's] service area.]] [I understand that if I omit or falsify any statement on this enrollment form, [Carrier] can cancel my coverage as of the original effective date.]
Any person who includes any false or misleading information on an application or enrollment form [and change form] for a health benefits plan is subject to criminal and civil penalties.

[Conditions of Acceptance

On behalf of myself and the dependents listed on this Enrollment Form, I agree to or with the following:

1. Employee is applying for coverage for the employee, employee'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 employee or the employee's spouse for support and maintenance or are unmarried children between the ages of nineteen (19) and twenty-three (23) who are enrolled as full-time students at an accredited school.
2. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the Contract.
3. The Contract will determine the rights and responsibilities of [covered persons] [members] [subscribers] and will govern in the event it conflicts with any benefits comparison, summary or other description of the health benefits plan.
4. As a condition to [receiving in-network] benefits, employee understands and agrees that (with the exception of emergency procedures as defined in the Contract) all [in-network] services, in order to be covered by [Carrier], must be performed either by a participating primary care physician or by the participating specialist, hospital or other provider as authorized by prior written referral from the participating primary care physician. [Out-of-network benefits are covered, as stated in the contract.]
5. Employee agrees to make payment directly to health care providers such copayments as are provided in the employer's health benefits plan.
6. Employee understands that this coverage will remain in effect regardless of the continued availability of a particular [primary care physician] [health care center] [other health care provider].
7. Employee acknowledges that [carrier's] participating providers, including all participating primary care physicians, are independent contractors and are not agents or employees of [Carrier].]

Authorization

1. I authorize the sources stated below to give to [Carrier], 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, 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.
2. 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.
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
[Date signed	Signature of Spouse, if providing information on the pre-existing conditions statement
Date signed	Signature of Child who is 18 or older, if providing information on the pre-existing conditions statement]

EXPLANATION OF BRACKETS

The form contains a combination of the data necessary for enrollment by an indemnity carrier as well as that necessary for enrollment by an HMO carrier. Each carrier should extract only that information which applies to the type of coverage for which the enrollment form will be used, and produce an appropriate enrollment form. However, if a carrier markets both indemnity and HMO plans, the carrier may elect to either create a single application that would contain data for both delivery systems, clearly identifying the sections that are unique to each delivery system, or the carrier may elect to create separate applications for each delivery system.

1. The terms Policy and Policyholder may be replaced with Contract and Contractholder or Plan and Planholder, as appropriate.
2. If the form is not to be used as a Change Form, omit the reference to Change Form in the caption as well as Section III. If a Carrier elects to use the form as a change form, the Carrier may include one or both of the sections: "Type of Activity; "Termination."
3. If the carrier does not utilize the Pre-Existing Conditions Statement, omit the reference in the caption as well as Section IV.
4. Telephone data may be omitted, at the option of the carrier.
5. The residency data should be included only in connection with an HMO enrollment.
6. Carriers may eliminate any item(s) from the Reason for Completion of this Form section for which the carrier uses a separate administrative form and does not intend to use this form.
7. If the form will not be used to process deletion, omit the references to deletions from Section II.
8. Items 3, 4 and/or 5 of Section II may be omitted, at the option of the carrier.
9. Items 8, 9 and/or 10 of Section II may be omitted, at the option of the carrier.
10. Section V should be included only in connection with enrollment for a managed care Plan. If more than one plan is being made available to the employees, the Enrollment Form should include plan selection information to enable the employee to select which plan he/she wishes to enroll in. Carrier may include plan or product names in the Plan Selection section.
11. The Conditions of Acceptance text in Section VI should only be included by HMO carriers.
12. A carrier may elect to omit item "d" of Section VI.
13. The signature of dependents should be omitted if the Pre-Existing Conditions Statement is not used.
14. The Waiver of Coverage Form, Exhibit T, may be printed as part of the enrollment form, at the option of the carrier.
15. The formatting and spacing of the charts may be modified for easier completion by the applicant.

Note: Whenever sections or items numbers are omitted, re-number the document as appropriate.

Repeal and New Rule, R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Exhibit was "Explanation of Brackets Small Employer Health Benefits".

EXHIBIT R (RESERVED)

Repealed by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Exhibit was "Enrollment Application and Change Form".

EXHIBIT S (RESERVED)

Repealed by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).

See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).

Exhibit was "Health Maintenance Organization (HMO) Enrollment Application (and Change Form) Small Employer Health BenefitsPlan for Employees and Dependants".

EXHIBIT T

[CARRIER]
SMALL EMPLOYER HEALTH BENEFITS WAIVER OF COVERAGE
Group Policy No. _____
Policyholder Name: _____
Employee Name: _____ Social Security #_____
Last First MI
Marital Status: [ ] Single [ ] Married [ ] Widowed [ ] Divorced
Date of Employment: _____ Date of Birth_____
I was given the opportunity to enroll in this plan of group health benefits offered by my employer and insured by [Carrier]. I *refuse* the following:
[ ] Employee, Spouse and Child(ren) coverage
[ ] Spouse coverage
[ ] Child(ren) coverage
Reason for Refusal (Please check all appropriate boxes.)
[ ] other group coverage sponsored by my employer
[ ] other group coverage sponsored by my spouse's employer
[ ] other group coverage sponsored by another organization
[ ] other reasons (please explain) _____
Please provide name of carrier and policy number: _____
I understand that if I later wish to enroll for any of the coverage(s) refused, I will be required to submit an Enrollment Form [and Pre-Existing Condition Statement], and coverage may be subject to a preexisting conditions exclusion.

_____ _____
Signature of Employee Date

_____ _____
Signature of Witness Date

Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).

EXHIBIT U

PART 1

(Reserved)

Amended by R.1994 d.55, effective December 30, 1993.
See: 26 N.J.R. 328(b), 26 N.J.R. 809(a).
Amended by R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).
Repealed by R.1997 d.126, effective March 17, 1997.
See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).
Part was "Reinsuring Carrier Declaration".

PART 2

(Reserved)

Amended by R.1994 d.55, effective December 30, 1993.
See: 26 N.J.R. 328(b), 26 N.J.R. 809(a).
Repealed by R.1997 d.126, effective March 17, 1997.
See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).
Part was "Risk-Assuming Carrier Declaration".

PART 3

(Reserved)

Amended by R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).
Repealed by R.1997 d.126, effective March 17, 1997.
See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).
Part was "Risk-Assuming Carrier Application".

EXHIBIT V

[Carrier] **PLAN A**

SMALL GROUP HEALTH BENEFITS [CERTIFICATE]

[[Carrier] certifies that the Employee named [below] is entitled to the benefits described in this [certificate], as of the effective date shown [below], subject to the eligibility and effective date requirements of the Policy.

This [certificate] replaces any and all [certificates] previously issued to the Employee under any group policies issued by [Carrier] providing the types of benefits described in this [certificate].

The Policy is a contract between [Carrier] and the Policyholder. This [certificate] is a summary of the Policy provisions that affect your insurance. All benefits and exclusions are subject to the terms of the Policy.

POLICYHOLDER:	[ABC Company]
GROUP POLICY NUMBER:	[G-12345]
EMPLOYEE:	[JOHN DOE]
CERTIFICATE NUMBER:	[C-1234567]
EFFECTIVE DATE:	[07-01-97]

[CERTIFICATE] INDEX

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Calendar Year Cash Deductible	
• for Hospital Confinement	None (Note: See Hospital Confinement Co-Payment)
• or Preventive Care	None
• for immunizations and lead screening for children	None
• for All Other Charges	
—per Covered Person	$250
[—per Covered Family	[$500.] [Note: Must be individually satisfied by 2 separate Covered Persons]] [$750]
Hospital Confinement Co-Payment	
—per day	$250
—maximum Co-Payment per Period of Confinement	$1,250
—maximum Co-Payment per Covered Person per Calendar Year	$2,500

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. The Policy's Co-Insurance, as shown below, does not include penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

The Co-Insurance for the Policy is as follows:

• for Preventive Care	None
• for Facility charges made by:	
—a Hospital	20%
—an Ambulatory Surgical Center	20%
—a Birthing Center	20%
—an Extended Care Center or Rehabilitation Center	20%
—a Hospice	20%
• for the following Covered Charges incurred while the Covered Person is an Inpatient in a Hospital:	
—Prescription Drugs	20%
—Blood Transfusions	20%
—Infusion Therapy	20%
—Chemotherapy	20%
—Radiation Therapy	20%
• for all other Covered Charges	50%
Co-Insurance Cap per Covered Person per each Calendar Year	$5,000

Daily Room and Board Limits

• During a Period of Hospital Confinement

For semi-private room and board accommodations, [Carrier] will cover charges up to the Hospital's actual daily semi-private room and board rate.

For private room and board accommodations, [Carrier] will cover charges up to the Hospital's average daily semi-private room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the Covered Person is being isolated in a private room because the Covered Person has a communicable disease, [Carrier] will cover charges up to the Hospital's actual private room charge.

For Special Care Units, [Carrier] will cover charges up to the Hospital's actual daily room and board charge for the Special Care Unit.

• During a Confinement in An Extended Care Center Or Rehabilitation Center

[Carrier] will cover the lesser of:

a. the center's actual daily room and board charge; or
b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:

- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Fertility Services

Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges

SCHEDULE OF INSURANCE EXAMPLE: PLAN A PPO

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Calendar Year Cash Deductible:	
• for Hospital Confinement	None (Note: See Hospital Confinement Co–Payment)
• for Preventive Care	None

• for immunization and lead screening for children	None
• for All Other Charges	
—per Covered Person	$250
—per Covered Family	[$500] Note: Must be individually satisfied by 2 separate Covered Persons **[$750]**

Hospital Confinement Co-Payment

—per day	$250
—maximum Co-Payment per Period of Confinement	$1,250
—maximum Co-Payment per Covered Person per Calendar Year	$2,500

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. The Policy's Co-Insurance, as shown below, does not include penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

	If treatment, services or supplies are given by: *a Network Provider*	*an Out-Network Provider*
The Co-Insurance for the Policy is as follows:		
• for Preventive Care	None	None
• for Facility charges made by:		
—a Hospital	None	20%
—an Ambulatory Surgical Center	None	20%
—a Birthing Center	None	20%
—an Extended Care Center or Rehabilitation Center	None	20%
—a Hospice	None	20%
• for the following Covered Charges incurred while the Covered Person is an Inpatient in a Hospital:		
—Prescription Drugs	None	20%
—Blood Transfusions	None	20%
—Infusion Therapy	None	20%
—Chemotherapy	None	20%
—Radiation Therapy	None	20%
• for all other Covered Charges	70%	50%

The **Coinsured Charge Limit** means the amount of Covered Charges a Covered Person must incur **each calendar year** before no Co-Insurance is required.

Coinsured Charge Limit: $10,000

Daily Room and Board Limits

• During a Period of Hospital Confinement

For semi-private room and board accommodations, [Carrier] will cover charges up to the Hospital's actual daily semi-private room and board rate.

For private room and board accommodations, [Carrier] will cover charges up to the Hospital's average daily semi-private room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the Covered Person is being isolated in a private room because the Covered Person has a communicable illness, [Carrier] will cover charges up to the Hospital's actual private room charge.

For Special Care Units, [Carrier] will cover charges up to the Hospital's actual daily room and board charge for the Special Care Unit.

• During a Confinement in An Extended Care Center Or Rehabilitation Center

[Carrier] will cover the lesser of:

a. the center's actual daily room and board charge; or
b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:

- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- **Fertility Services**

Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges

Payment Limits: For Illness or Injury, [Carrier] will pay up to the payment limit shown below:

Charges for Inpatient Hospital confinement	30 days
Charges for Home Health Care	exchange basis* for Hospital days
Charges for Extended Care or Rehabilitation Center Care	exchange basis* for Hospital days
Charges for Hospice Care	exchange basis* for Hospital days

* See the **Covered Charges** section for a description of the exchange rules.

Charges for Preventive Care per Calendar Year (Not subject to Cash Deductible or Co-Insurance)	
—per Covered Person	$100
[—per Covered Family	$300]
Per Lifetime Maximum Benefit (for all Illnesses and Injuries)	$1,000,000

GENERAL PROVISIONS

INCONTESTABILITY OF THE POLICY