

**CHAPTER 20**

**INDIVIDUAL HEALTH COVERAGE PROGRAM**

**Authority**

N.J.S.A. 17:1-8.1 and 15e, and 17B:27A-2 et seq.

**Source and Effective Date**

R.1998 d.443, effective August 7, 1998 and R.1998 d.454, effective August 13, 1998.

See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a);  
30 N.J.R. 2192(a), 30 N.J.R. 3308(a).

**Chapter Expiration Date**

The expiration date of Chapter 20, Individual Health Coverage Program Rules, was extended by gubernatorial directive to July 4, 2005. See: 37 N.J.R. 778(a).

**Chapter Historical Note**

Chapter 20, Individual Health Coverage Program, was adopted as emergency new rules by R.1993 d.344, effective June 14, 1993 (to expire August 13, 1993). See: 25 N.J.R. 2945(a). The concurrent proposal of Chapter 20 was adopted as R.1993 d.439, effective August 13, 1993, with changes effective September 7, 1993. See: 25 N.J.R. 2945(a), 25 N.J.R. 4180(a).

Subchapter 2, Individual Health Coverage Program Temporary Plan of Operation, was adopted as R.1993 d.550, effective October 14, 1993. See: 25 N.J.R. 4707(a), 25 N.J.R. 5244(a).

Subchapter 10, Performance Standards and Reporting Requirements, was adopted as R.1994 d.142, effective February 23, 1994. See: 26 N.J.R. 1202(a), 26 N.J.R. 1351(a).

Subchapter 11, Relief from Obligations Imposed by the Individual Health Insurance Reform Act, was adopted as R.1993 d. 654, effective December 30, 1993. See: 25 N.J.R. 4459(a), 25 N.J.R. 5930(b).

Subchapter 12, Eligibility for and Replacement of Standard Health Benefits Plans, was adopted as R.1994 d.54, effective December 30, 1993. See: 26 N.J.R. 87(a), 26 N.J.R. 804(a).

Subchapter 13, Certification of Non-Member Status, was adopted as R.1994 d.177, effective March 10, 1994. See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).

Subchapter 17, Enrollment Status Report, was adopted as R.1994 d.53, effective December 30, 1993. See: 26 N.J.R. 90(a), 26 N.J.R. 806(a).

Subchapter 18, Withdrawal of Carriers from the Individual Market and Withdrawal of Plan, Plan Option, or Deductible/Copayment Option, was adopted as R.1998 d. 339, effective July 6, 1998. See: 29 N.J.R. 2615(a), 30 N.J.R. 2502(a).

Pursuant to Executive Order No. 66(1978), Chapter 20, Individual Health Coverage Program, Subchapters 1 through 10, 12, 13, 17, 18 and Appendix Exhibits A through T, were readopted as R.1998 d.443, effective August 7, 1998, and Subchapter 11 was readopted as R.1998 d.454, effective August 13, 1998. Subchapter 19, Petitions for Rule-making, and Subchapter 20, Appeals from Actions of the Board, were adopted as new rules by R.1998 d.443, effective August 7, 1998. See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a); 30 N.J.R. 2192(a), 30 N.J.R. 3308(a).

In accordance with N.J.S.A. 52:14B-5.1d, the expiration date of Chapter 20, Individual Health Coverage Program, was extended by gubernatorial directive from August 7, 2003 to 270 days following Supreme Court decision in *In re Health Coverage Program's Readoption of N.J.A.C. 11:20-1.1 et seq.* 35 N.J.R. 2898(a).

In accordance with N.J.S.A. 52:14B-5.1d, Chapter 20, Individual Health Coverage Program, expiration date was extended by gubernatorial directive from February 4, 2005 to July 4, 2005. See: 37 N.J.R. 778(a).

**Case Note**

New Jersey Individual Health Coverage Program Board of Directors did not violate authorized procedures for adopting or amending its regulations when it readopted Individual Health Coverage Program (IHCP) regulations; Board provided notice as required by statute, received written comments regarding proposed regulations, and prepared report that summarized and responded to comments and was published in New Jersey Register. In re N.J. IHCP, 353 N.J.Super. 494, 803 A.2d 639.

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**SUBCHAPTER 1. GENERAL PROVISIONS**

**11:20-1.1 Purpose and scope**

(a) This chapter implements provisions of P.L. 1992, c.161 (N.J.S.A. 17B:27A-2 et seq.), the Individual Health Insurance Reform Act, as amended. This chapter establishes procedures and standards for carriers to meet their obligations under N.J.S.A. 17B:27A-2 et seq., and establishes procedures and standards applicable for the fair, reasonable and equitable administration of the Individual Health Coverage Program pursuant to N.J.S.A. 17B:27A-2 et seq.

New Rule, R.2003 d.91, effective January 28, 2003.  
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

Amended by R.2003 d.91, effective January 28, 2003.  
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

Inserted "and the basic and essential health care services plan with an effective date on or after January 1, 2003," following "August 1, 1993".

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#### SUBCHAPTER 4. STANDARD APPLICATION FORM

##### 11:20-4.1 Standard application form

All members offering standard health benefits plans with an effective date on or after August 1, 1993, and the basic and essential health care services plan with an effective date on or after January 1, 2003, shall use the standard application form approved by the Board and specified in Exhibit G with the variable text explained on the Explanation of Brackets, Exhibit T of the Appendix to this chapter.

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).

Administrative Correction.

See: 27 N.J.R. 1424(a).

Amended by R.1998 d.443, effective August 7, 1998.

See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).

Rewrote the section.

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#### SUBCHAPTER 5. STANDARD CLAIM FORM

##### 11:20-5.1 Standard claim form

All members offering health benefits plans or other health insurance policies to individuals, to the extent that the member uses claims forms in its transaction of business (rather than an electronic billing system), shall require as a condition of payment, the standard claims form approved by the Board and set forth as Exhibit H in the Appendix to this chapter, incorporated herein by reference. The HCFA 1500 form and patient instructions set forth in Exhibit H shall be the standard claim form for all medical expenses incurred for services other than hospital inpatient services. The form UB-92 set forth as Exhibit I shall be the standard claim form for all hospital inpatient services.

Amended by R.1998 d.443, effective August 7, 1998.  
 See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).  
 Rewrote the section.

## SUBCHAPTER 6. INDIVIDUAL HEALTH BENEFITS CARRIERS INFORMATIONAL RATE FILING REQUIREMENTS

### 11:20-6.1 Purpose and scope

The purpose of this subchapter is to establish informational rate filing requirements and procedures for members issuing or renewing individual health benefits plans pursuant to sections 2b(1) and 3 of the Act (N.J.S.A. 17B:27A-3b(1) and 17B:27A-4), as well as the basic and essential health care services plan pursuant to P.L. 2001, c.368.

Amended by R.2003 d.91, effective January 28, 2003.  
 See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

Inserted "as well as the basic and essential health care services plan pursuant to P.L. 2001, c.368" following the N.J.S.A. references.

### 11:20-6.2 Definitions

Words and terms, when used in this subchapter, shall have the meanings defined by the Act, N.J.A.C. 11:20-1.2, or as further defined below, unless the context clearly indicates otherwise.

"Informational filing" means a submission by a carrier of rate manuals which specify the plans offered, premium rates, all factors to be used in the calculation of premium rates, and a detailed actuarial memorandum supporting the calculation of the rates, a certification by a member of the American Academy of Actuaries, all supporting data for the premium rates and such other information as the Board from time to time requests or requires.

### 11:20-6.3 Informational rate filing requirements

(a) All members issuing standard health benefits plans on a new contract or policy form and the basic and essential health care services plan shall make, prior to issuing any of these health benefits plans, an informational rate filing with the Board, which shall include the following supporting data:

1. Rate manuals specifying the standard health benefits plans and the basic and essential health care services plan, with riders, if any, offered. The manuals shall not include references to, or premiums containing assumptions based upon, an individual's claims experience, underwriting, substandard ratings, occupational limitations or any other factors prohibited by the Act, except that the rates for the basic and essential health care services plan and any riders thereto may consider age, gender and geography, as permitted by P.L. 2001, c.368 and N.J.A.C. 11:20-6.5;

2. Premium rates and any factors used in the calculation of the premium rates and the effective dates for the rates. The premium rates may be for a period of effective dates not to exceed 12 months from the initial effective date. Unless a carrier amends the rate filing to specify an alternative effective date, carriers shall use the rates shown in the rate filing, as of the stated effective date. Rates may be developed on different rate tiers for: single, husband/wife; adult/child(ren); family; and with respect to the basic and essential health care services plan, and any riders thereto, a description of the rating methodology or plan and the numerical value of the classification factors utilized in determining a policyholder's rates that addresses the use of the factors of age, gender and geography as discussed in (a)2i, ii and iii below, provided that all proposed rates applicable in the State have been filed with the Board before being used to quote new business or renewals. The filing for the basic and essential health care services plan shall include:
  - i. The numerical value of the classification factors utilized in the calculation of an individual's premium rate or rates, limited to: age, gender, geographic location, effective date, and rating tier of each covered adult in accordance with the factors set forth in N.J.A.C. 11:20-6.5;
  - ii. A written description (non-formulaic) of the rating methodology in plain language so that a knowledgeable member of the public may understand how to translate the basic rates into the rates charged for an individual policy; and
  - iii. A detailed example calculation, in the proposal format used by the carrier, for the basic and essential health care services plan, including any rider option(s), showing all the steps to develop premiums for a policy and demonstrating the adjustment, if any, to achieve the required 350 percent maximum ratio between premiums for the highest rated individual policyholder and the lowest rated individual policyholder in the State;

3. A detailed actuarial memorandum, which shall include the following:
  - i. The rates being submitted;
  - ii. All information used in the development of the rates;
  - iii. The anticipated loss experience and the assumptions used in developing such anticipated loss experience, including historical experience, trend assumptions, plan relativity assumptions, and any other factors used in developing the anticipated loss experience; and
  - iv. The administrative expense, premium tax and commission payment assumptions, and other margins;

4. A certification signed by a member of the American Academy of Actuaries, which shall include the following:

i. A statement that the informational filing is complete;

ii. A statement that the carrier's loss ratio is expected to be at least 75 percent;

iii. For rates to be charged for the basic and essential health care services plan, and any optional benefit riders thereto, a statement that the rating methodology will not produce rates (for each rate tier) for the highest rated policyholder which are greater than 350 percent of the rates (for each rate tier) for the lowest rated policyholder for each basic and essential health care services plan and rider option; and

iv. For rates to be charged for the basic and essential health care services plan, and any optional benefit riders thereto, the anticipated loss ratio for the plan; and

5. Such other information or data as may be required or requested by the Board to analyze the adequacy of the rate filing submitted.

(b) Any member which seeks to change its rates for its standard health benefits plans, its basic and essential health care services plan, or its community rated health benefits plans issued prior to August 1, 1993 shall, prior to the effective date of the revised rates, submit to the Board an informational rate filing, which shall include all the supporting data set forth in (a) above.

Amended by R.1998 d.443, effective August 7, 1998.  
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).

Rewrote the section.

Amended by R.2003 d.91, effective January 28, 2003.  
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

Rewrote (a); in (b), inserted "its basic and essential health care services plan" preceding "or its community rated".

#### 11:20-6.4 Informational rate filing procedures

(a) The informational rate filing filed by the member with the Board pursuant to N.J.A.C. 11:20-6.3(a) or (b) shall be filed in triplicate to the Executive Director at the address set forth in N.J.A.C. 11:20-2.1(h).

(b) If the Board determines that an informational filing filed pursuant to N.J.A.C. 11:20-6.3(a) or (b) is incomplete, the Board shall provide written notice to the member specifying those portions of the filing which are deficient and the information required to be submitted or resubmitted by the member.

(c) Upon 15 days of receipt of written notice in (b) above, the member shall provide the Board with the information required to complete the filing.

(d) Upon notice that the filing is incomplete, the member shall not use the filed rates until the Board has determined that the informational filing is complete, and written notice of that fact has been provided to the member.

Administrative Change.

See: 27 N.J.R. 1423(a).

Amended by R.1998 d.443, effective August 7, 1998.

See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).

Rewrote (a); and deleted former (e).

#### 11:20-6.5 Permissible rate classification factors

(a) For a basic and essential health care services plan issued or renewed on or after January 1, 2003, a carrier shall not differentiate premium rates charged to different individuals for the basic and essential health care services plan and rider(s), if any, except on the basis of age, gender, and geography in accordance with the following restrictions:

1. Age factor categories shall be limited to the following increments: 24 and under; 25-29; 30-34; 35-39; 40-44; 45-49; 50-54; 55-59; 60-64; 65-69; 70 and over.

2. Geographic categories shall be limited to six territories, each consisting of the areas covered by the first three digits of the U.S. Postal Service zip codes or the counties listed below. A carrier shall determine which territory applies to a policyholder on the basis of the address of the policyholder's place of residence. The six territories are the following:

i. Territory A consists of zip codes 070-073 or Essex, Hudson and Union counties;

ii. Territory B consists of zip codes 074-076 or Bergen and Passaic counties;

iii. Territory C consists of zip codes 077-079 or Monmouth, Morris, Sussex and Warren counties;

iv. Territory D consists of zip codes 088-089 or Hunterdon, Middlesex and Somerset counties;

v. Territory E consists of zip codes 081, 085-086 or Burlington, Camden and Mercer counties; and

vi. Territory F consists of zip codes 080, 082-084 and 087 or Atlantic, Cape May, Ocean, Salem, Cumberland and Gloucester counties.

(b) Notwithstanding (a) above, a carrier may differentiate premium rates on the basis of family structure according to only the following four rating tiers:

1. Single;
2. Husband and wife;
3. Adult and child(ren); and
4. Family.

New Rule, R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

## [EXHIBIT G]

APPLICATION FOR INDIVIDUAL HEALTH BENEFITS PLAN  
FOR INDIVIDUALS AND FAMILIES

## 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 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 is 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 your coverage shall be January 1 of the following calendar year. Current coverage should not be terminated until new coverage is in effect.

## INDIVIDUAL APPLICATION INSTRUCTIONS

BEFORE COMPLETING THIS APPLICATION BE SURE TO FAMILIARIZE YOURSELF WITH THE BENEFIT OPTIONS AVAILABLE. [NOTE: [CARRIER'S] PARTICIPATING PROVIDERS, INCLUDING ALL [PARTICIPATING] [NETWORK] PRIMARY CARE PHYSICIANS, ARE INDEPENDENT CONTRACTORS AND ARE NOT AGENTS OR EMPLOYEES OF [CARRIER].]

COMPLETE ALL SECTIONS IF YOU ARE:

1. [Applying] [Enrolling] as a new [insured] [enrolled] [subscriber] [member].
2. Changing dependent coverage.

COMPLETE SECTIONS 1, 2, 3, [AND] [5] AND [6] IF YOU ARE TERMINATING YOUR COVERAGE.

Section 1—Print your full name along with the name(s) of your spouse and dependent children you wish to cover, if any. Provide date of birth, sex, and social security number for each individual listed. Your social security number is for our use. The New Jersey Individual Health Coverage Program Board will not collect or use your social security number. If a dependent is a full-time college student, you **must** attach a current course schedule or tuition receipt. If a dependent is beyond age 19 or 23, as applicable, but is mentally or physically handicapped or developmentally disabled, unmarried and chiefly dependent upon the applicant or applicant's spouse for support and maintenance, a physician's statement as to the dependent's physical or mental incapacity must be provided. The add/remove blocks should be checked **only** if you wish to add or remove a dependent from the plan.

Section 2—Complete all information.

Section 3—Check box(es) indicating options for coverage, type of contract, [payment plan] and reason(s) for submitting form (i.e., new enrollment, coverage change, name change, withdrawal).

Section 4—This information is required. Please complete all information.

[Section 5—For applicants only] From the appropriate [directory] [brochure] [ ] choose [the location number for] a Primary Care Physician [or Health Center] [and/or Gynecologist if applicable,] [for yourself and each member of your family] [required for all members]. [If you choose a Health Center, you must choose a Primary Care Physician who services that Health Center.] [Indicate whether you are choosing [carrier's] Statewide Physician Network or Health Center.] Check the change box only if you are changing providers.

Section [5/6]—Applicant must sign this section and date this form or it will not be processed.

## CONDITIONS OF ACCEPTANCE

On behalf of myself and the dependents listed [on the following page,] [on the reverse side,] I agree to or with the following:

1. Coverage of applicant and of the listed dependents shall depend on acceptance by [carrier] after a review of the application [and receipt of payment].
2. Applicant is applying for individual coverage for the applicant, applicant's spouse and any eligible unmarried children under nineteen (19) years of age, unmarried children who are mentally or physically incapacitated or developmentally disabled, who are chiefly dependent upon the applicant or the applicant's spouse for support and maintenance, or are unmarried children between the ages of nineteen (19) and twenty-three (23) who are full-time students at an accredited educational institution.

3. Coverage and benefits are contingent on timely payment of premiums. Coverage may be terminated as provided in the Individual [Contract] [Policy].
4. The Individual [Contract] [Policy] will determine the rights and responsibilities of [insured(s)] [enrollee(s)] [subscriber(s)] [member(s)] and will govern in the event it conflicts with any benefits comparison, summary or other description of the health benefits plan.
5. [As a condition to benefits, applicant understands and agrees that (with the exception of a medical emergency as defined in the Individual [Contract] [Policy] all services, in order to be covered by [Carrier], must be performed either by a Primary Care Physician or by the specialist, hospital or other provider as authorized by prior written referral from the Primary Care Physician [or Care Manager].]
6. [[If applicable,] Applicant agrees to make payment directly to health care providers, such copayments as are provided for in the Individual [Contract] [Policy].]
7. [Applicant understands that this coverage will remain in effect regardless of the continued availability of a particular [Health Center], Primary Care Physician or other health care provider.]
8. [Applicant acknowledges that [Carrier's] participating providers, including all participating primary care physicians, are independent contractors and are not agents or employees of [Carrier].]

Please print in ink all information requested on this application.

1. Eligible Persons to be Enrolled. (Note: Dependent children may be covered under an adult-child(ren) or family contract only while unmarried and until [they attain] age 19, or 23 if full-time students. Unmarried, handicapped dependent children can continue beyond the age limits above as long as they remain incapacitated and unmarried.\*

This section must be completed in its entirety.

LAST NAME	FIRST NAME	MI	BIRTHDATE			SEX	Social Security Number
			MO	DAY	YR	M or F	
Applicant 1. ' Add ' Remove							____-____-____
Spouse 2. ' Add ' Remove							____-____-____
Child 3. ' Add ' Remove							____-____-____
Child 4. ' Add ' Remove							____-____-____
Child 5. ' Add ' Remove							____-____-____

\*Attach sheet to list additional children. [Attach proof if full-time student. Totally disabled children will be covered regardless of age. Attach proof of disability.]

**DEPENDENT INFORMATION**

Do any of the dependents listed in #1 live at another address?      ' Yes      ' No

If yes, who and at what address?

\_\_\_\_\_

Explain the circumstances.

\_\_\_\_\_

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

\_\_\_\_\_

- 2. PRIMARY RESIDENCE (Note: You must be a Resident, which is defined as follows: a person:
  - whose primary residence is in New Jersey and who is present in New Jersey for at least six months of the Calendar Year; or
  - in the case of a person who has moved to New Jersey less than six months before applying for coverage, who intends to be present in New Jersey for at least six months of the Calendar Year.

Street \_\_\_\_\_ Apt. \_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

[Do you live, reside or work in the [Carrier's] service area? ' Yes ' No]

TELEPHONE NUMBER

Home ( ) - Work ( ) - Best place to call during day: ' Home ' Work

Are you a resident of the State of New Jersey? ' Yes ' No

Do you maintain a residence in any other state? ' Yes ' No

If "Yes," (a) Name of state \_\_\_\_\_ (b) How much time do you spend there each year? \_\_\_\_\_

[[If you or any of your dependents are covered under an existing health benefits plan, or if you or any of your dependents had coverage which terminated within the past 31 days, please provide the following information for each person who has or had such coverage.

Name(s) of Person(s): \_\_\_\_\_

Name of Carrier: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Type of Coverage: Check all that apply.
\_\_\_\_\_ Group \_\_\_\_\_ Individual
\_\_\_\_\_ Indemnity \_\_\_\_\_ HMO \_\_\_\_\_ PPO \_\_\_\_\_ Point of Service
\_\_\_\_\_ Other (Specify) \_\_\_\_\_

Plan Information: Deductible Amount: \_\_\_\_\_

Coinsurance: \_\_\_\_\_

Copayment: \_\_\_\_\_

Initial Effective Date: \_\_\_\_\_ Termination Date: \_\_\_\_\_

If one or more of the persons are or were covered under a separate plan, please use this section to provide information concerning the coverage for those persons.

Name(s) of Person(s): \_\_\_\_\_

Name of Carrier: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Type of Coverage: Check all that apply.
\_\_\_\_\_ Group \_\_\_\_\_ Individual
\_\_\_\_\_ Indemnity \_\_\_\_\_ HMO \_\_\_\_\_ PPO \_\_\_\_\_ Point of Service

\_\_\_\_ Other (Specify)\_\_\_\_\_

Plan Information: Deductible Amount: \_\_\_\_\_  
Coinsurance: \_\_\_\_\_  
Copayment: \_\_\_\_\_

Initial Effective Date: \_\_\_\_\_ Termination Date: \_\_\_\_\_]]

-----  
COVERAGE (Please mark Coverage, Type of Contract and Type of Activity)

PLEASE ENROLL ME (AND MY DEPENDENTS) IN: (Only one plan and one deductible option may be selected)

[PLAN A/50 Deductible \$1000 \_\_\_\_\_ \$2500 \_\_\_\_\_  
\$5000 \_\_\_\_\_ \$10000 \_\_\_\_\_  
PLAN B [ ' Indemnity ] [ ' Preferred Provider ] Deductible \$1000 \_\_\_\_\_ \$2500 \_\_\_\_\_  
PLAN C [ ' Indemnity ] [ ' Point of Service ] [ ' Preferred Provider ] Deductible \$1000 \_\_\_\_\_ \$2500 \_\_\_\_\_ [per individual  
\$1500 \_\_\_\_\_ \$2250 \_\_\_\_\_ per family \$3000 \_\_\_\_\_ \$4500 \_\_\_\_\_]  
\$1650 \_\_\_\_\_ \$2500 \_\_\_\_\_ per family \$3300 \_\_\_\_\_ \$4950 \_\_\_\_\_]

PLAN D [ ' Indemnity ] [ ' Point of Service ] [ ' Preferred Provider ] Deductible \$500 \_\_\_\_\_ \$1000 \_\_\_\_\_ [per individual  
\$1500 \_\_\_\_\_ \$2250 \_\_\_\_\_ per family \$3000 \_\_\_\_\_ \$4500 \_\_\_\_\_]  
\$1650 \_\_\_\_\_ \$2500 \_\_\_\_\_ per family \$3300 \_\_\_\_\_ \$4950 \_\_\_\_\_]

[HMO Plan [\$10] \$15 [\$20] [\$30] copayment.] [Well Child Care Option ' Yes ' No]]

**Basic and Essential health Care Services Plan**

[Optional benefit Riders available with the basic and essential health care services plan (carrier should list the riders, if any)]

Type of Contract: ' Single  
' Family  
' Adult & Child(ren)  
' Husband/Wife  
' Child(ren)

[If you selected Plan C or Plan D with a [\$1500 per individual] [[\$2250]2500 per individual] [\$3000 per family] [[\$4500]4950 per family]  
Deductible option, do you intend to participate in a Medical Savings Account?  
' Yes ' No]

Requested Effective Date - [Must be the 1st or 15th of the month]: \_\_\_\_\_

Type of Activity:

' New [Subscriber] ' Name Change from \_\_\_\_\_ to \_\_\_\_\_  
' Converting from existing (carrier) plan ID # \_\_\_\_\_ [' Change of Primary Care Physician or Gynecologist]  
' Add/Remove Dependent Reason \_\_\_\_\_ Date of Event \_\_\_\_\_ [' Change of Health [Care] Center from \_\_\_\_\_ to \_\_\_\_\_]  
' Withdrawal From Coverage Date of Event \_\_\_\_\_

SELECT THE PAYMENT PLAN YOU DESIRE

' Monthly [ ' Quarterly] [ ' Semi-Annually]

[PAYMENT MODE:  
' Check  
' Money Order

[ ' Credit Card Type \_\_\_\_\_ No. \_\_\_\_\_ Exp. Date \_\_\_\_\_ ]  
 [ ' Automatic Bank Draft (attach voided check)]  
 [ ' Other \_\_\_\_\_ Amount \$ \_\_\_\_\_ ]]

4. OTHER HEALTH CARE COVERAGE (Note: In some situations, if you are eligible for or have other health benefits coverage, you are not eligible for this [policy] [coverage]. If you or other dependents become eligible for or become covered under other health benefits coverage, after the date of this application, you must notify us as soon as possible, however no later than the effective date of such other coverage.)

Are you employed?      ' Yes      ' No      If yes, please give name and address of your employer.
Are you eligible for other health benefits coverage?      ' Yes      ' No (i.e., coverage under your employer's health benefits coverage or Medicare).
If yes, give name and policy no. of other carrier or type of coverage.
Are other dependents eligible for coverage? If yes, specify.
Do you or other dependents currently have any other health care coverage?      ' Yes      ' No
If yes, give name and policy/certificate no. of other carrier, initial effective date of coverage and specify those covered by the policy/certificate:
Are you replacing existing coverage?      ' Yes      ' No
If yes, give name and policy no. of other carrier, initial effective date of coverage, date of termination, and specify those covered by policy. If you are replacing coverage and the plan is an Individual Health Coverage (IHC) Plan or a Small Employer Health Benefits (SEH) Plan, please identify the letter of the plan being replaced. _____
Were you, or any dependent(s) to be covered, covered under a prior Group Health Plan?      ' Yes      ' No If "Yes," attach the Certificate of Creditable Coverage
[Have you or your dependents ever been a member of [carrier]?]
[If yes, under what name and social security no.?)
[Where? [carrier] of:]

**[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 12 months. Consult the Buyer's Guide, the carrier or your agent for information concerning the application of the pre-existing conditions limitation.

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

	Yes	No
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	_____	_____



medical advice, diagnosis, care, or treatment, or (c) pregnancy existing on the effective date of this [policy] [contract]. (Note: This limitation will not apply if you are a Federally Defined Eligible Individual and 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 live or work 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][immediately].

Applicant's Signature: \_\_\_\_\_ Date Signed \_\_\_\_\_

Spouse's Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

Preparer's Signature: \_\_\_\_\_ DOBI 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.

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

[[6][7] AGENT/PRODUCER INFORMATION

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

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).  
 Amended by R.1997 d.477, effective January 1, 1998.  
 See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).  
 Amended by R.1998 d.443, effective August 7, 1998.  
 See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).  
 Amended by R.1998 d.503, effective September 16, 1998 (operative November 1, 1998).

See: 30 N.J.R. 3235(b), 30 N.J.R. 3838(a).  
 Amended by R.1999 d.131, effective March 25, 1999.  
 See: 31 N.J.R. 834(a), 31 N.J.R. 1104(a).  
 Amended by R.2002 d.95, effective March 18, 2002 (operative August 1, 2002).  
 See: 33 N.J.R. 4057(a), 34 N.J.R. 1277(a).  
 Amended by R.2002 d.331, effective October 7, 2002.  
 See: 34 N.J.R. 1786(a), 34 N.J.R. 3527(a).  
 Amended by R.2003 d.91, effective January 28, 2003.  
 See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).





**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 sanatorium 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.1998 d.443, effective August 7, 1998.  
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).  
Section was "Exhibit I".

**EXHIBIT J**  
 Loss Ratio Report Form  
 New Jersey Individual Health Coverage Program

Reporting Year \_\_\_\_\_, 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 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 x (ii ÷ iii)] = \$ \_\_\_\_\_
    - i. Total net paid loss assessment \$ \_\_\_\_\_
    - ii. Net earned premium for standard health benefits plans \$ \_\_\_\_\_
    - iii. Net earned premium for all health benefits plans \$ \_\_\_\_\_
- C. Loss Ratio (B ÷ A) = \_\_\_\_\_ (If less than 75%, fill out D and E below)