



**APPLICATION FOR A SMALL EMPLOYER HEALTH BENEFITS POLICY**

WellChoice Insurance of New Jersey, Inc.  WellChoice HMO of New Jersey

PLEASE PRINT OR TYPE  New policy  Change in policy Policy Number: \_\_\_\_\_  
Sales Rep.: \_\_\_\_\_ Code: \_\_\_\_\_ Requested Effective Date: \_\_\_/\_\_\_/\_\_\_

Note: The Effective Date will be on or after the date WellChoice approves the application.

**SECTION I: POLICYHOLDER INFORMATION**

1. Policyholder (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: \_\_\_\_\_
5. Type of organization:  Corporation  Partnership  Proprietorship  Other \_\_\_\_\_
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 & Dependents  
Should the plan provide coverage for domestic partners as permitted by P.L. 2003, c. 246?  Yes  No  
If yes, should the plan provide coverage to children of a covered domestic partner?  Yes  No
11. Are you subject to the requirements of COBRA?:  Yes  No
12. Is the employer subject to the requirements of Medicare as Secondary Payor Rules for eligibility due to age?  Yes  No  
due to disability?  Yes  No
13. Waiting period before employees become insured: (may not exceed 6 months)  
Present Employees: \_\_\_\_\_ New/Rehired Employees: \_\_\_\_\_
14. What percentage of the premium will the employer pay? \_\_\_\_\_ %
15. Deposit \$ \_\_\_\_\_ Premium paid:  Monthly  Quarterly

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	Number Eligible Employees in This Company	Number Eligible Employees to Be Insured

**SECTION II: SPECIFICATIONS FOR COVERAGE**

**HEALTH BENEFITS**

PPO C 100/70

**CO-PAY**     \$10     \$20     \$30

**DEDUCTIBLE**  \$250     \$500

\$1,000     \$2,500

PPO C 90/70

NA

\$250     \$500  
 \$1,000     \$2,500

HMO

Access HMO

Home/Office Medical Co-payments:  
 \$5     \$10     \$15     \$20     \$30     \$50

Hospital Copayment Options:     Standard hospital copayment option  
 \*\$0 Hospital Co-payment Rider

Hospital per admission co-payment options

\$500/\$1,000\*\*     \$1,000/\$2,000\*\*    \*Available With all home/office co-payment options  
\*\*only available with the \$5, \$10, \$15, \$20 and \$30 home office co-payments  
 \$1,500/\$3,000\*\*     \$2,500/\$5,000\*

**INDEMNITY HEALTH BENEFITS PLANS:**

Deductible Options

- Plan A     \$250
- Plan B     \$250     \$500     \$1000
- Plan C     \$250     \$500     \$1000
- Plan D     \$250     \$500     \$1000
- Plan E     \$150

**PRESCRIPTION DRUG BENEFITS**

- Standard**<sup>1,2</sup>     **Option 1**<sup>1</sup>     **Option 2**<sup>1</sup>     **Option 3**<sup>2</sup>     **Option 4**<sup>2</sup>
- \$15-\$15     \$15-\$0/\$5     \$5/\$10-\$0/\$5     (check each selection)     (check each selection)
- Retail-Mail Order     Retail-Mail Order     Retail-Mail Order     \$10/\$20/\$30     \$10/\$25/\$50
- Rx Deductible     Rx Deductible
- \$0     \$100     \$150     \$0     \$100     \$150
- Oral Contraceptives     Oral Contraceptives
- Yes     No     Yes     No

<sup>1</sup>Standard, Option 1 and Option 2 have \$0 deductible and include oral contraceptives.  
<sup>2</sup> Standard, Option 3 and Option 4 Prescription Drug Benefit plans are not available with the Indemnity Health Benefits Plans.

**SECTION III: ALL QUESTIONS MUST BE ANSWERED**

- Is there any Group Health Plan:
  - Now in force and to be continued?  Yes     No
  - Currently being applied for?  Yes     No
 If "Yes" identify the name of the Group Health Plan, give a description of the plan(s) and name of insurance carrier(s):  
 \_\_\_\_\_

- 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
- Has your firm been uninsured for three or more months prior to application?  Yes     No
- What forms of insurance are now or were in force?  Health Benefits     Prescription Drugs  
 (Attach copies of Booklet/Certificates and most recent Billing Statement.)
- Are extended benefits provided in case of termination of health benefits?  Yes     No
- 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 continuation.

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
				/ / to / /	/ / to / /
				/ / to / /	/ / to / /

**SECTION III: ALL QUESTIONS MUST BE ANSWERED (continued)**

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

7. To the best of your knowledge: Are any employees or dependents presently incapacitated?  Yes  No  
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.

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8. Does the employer participate in an arrangement with a Professional Employer Organization?  Yes  No (Refer to Advisory Bulletin 00-SEH-02 if you need information concerning what constitutes a Professional Employer Organizations.)

**SECTION IV: AGENT/PRODUCER INFORMATION**

**General Agency Name:** \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ Facsimile: \_\_\_\_\_

**Broker's Name/Agent of Record:** \_\_\_\_\_

Social Security Number: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ Facsimile: \_\_\_\_\_

**Broker's Signature:** \_\_\_\_\_

Split: \_\_\_\_\_

2nd Broker (if applicable)

**Broker's Name/Agent of Record:** \_\_\_\_\_

Social Security Number: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ Facsimile: \_\_\_\_\_

**Broker's Signature:** \_\_\_\_\_

Split: \_\_\_\_\_

Are you currently licensed with WellChoice?  Yes  No (If no, please complete Licensing Paperwork.) If not, complete your commission payments or this account may be delayed.

**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 WellChoice HMO of New Jersey and/or WellChoice Insurance of New Jersey, Inc. to make or modify any request or application for insurance or to bind WellChoice HMO of New Jersey and/or WellChoice Insurance of New Jersey, Inc. 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 WellChoice HMO of New Jersey and/or WellChoice Insurance of New Jersey, Inc. 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 on \_\_\_\_/\_\_\_\_/\_\_\_\_ at \_\_\_\_\_

\_\_\_\_\_  
**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.

**SECTION VI: FOR INTERNAL USE ONLY**

Effective Date: \_\_\_\_\_

Renewal Date: \_\_\_\_\_

New Account: \_\_\_\_\_

Conversion: \_\_\_\_\_

PPO          HMO          Access HMO          Indemnity

\_\_\_\_\_ Total Number of Applications Submitted

\_\_\_\_\_ Number of Waivers

Pre-X Applies:    Yes    No

\_\_\_\_\_ Number of Refusals

\_\_\_\_\_ % of Participation

**Cashier's Department**

Check Amount: \_\_\_\_\_

PPO Option 1: \_\_\_\_\_ Sub: \_\_\_\_\_

ACCOUNT NUMBER

PPO Option 2: \_\_\_\_\_ Sub: \_\_\_\_\_

ACCOUNT NUMBER

HMO: \_\_\_\_\_ Sub: \_\_\_\_\_

ACCOUNT NUMBER

Access HMO: \_\_\_\_\_ SUB: \_\_\_\_\_

ACCOUNT NUMBER

**Signatures**

Imp: \_\_\_\_\_  
(Print)

Date Received: \_\_\_\_\_

Released: \_\_\_\_\_

Sales Rep: \_\_\_\_\_  
(Print)

Sales Rep. Code: \_\_\_\_\_

NJ DSC: \_\_\_\_\_  
(Print)

Date Received: \_\_\_\_\_

Processed: \_\_\_\_\_

Broker Relation: \_\_\_\_\_  
(Print)

Date Received: \_\_\_\_\_

Processed: \_\_\_\_\_