AmeriHealth.
NEW JERSEY

Verification of Requirements

The AmeriHealth contract states that a dependent may be covered to age 30 if he or she meets certain criteria:

- The dependent's parent remains covered by the plan, and
- the employer retains coverage with AmeriHealth, and
- Contributions are made by or on behalf of the dependent.

In order to request continued coverage, AmeriHealth requires a verification form be completed indicating that all of the criteria have been met.

Payment. The dependent shall be required to pay up to 102% of the dependent premium. The dependent will be billed directly for this cost. The initial premium payment is required at the time of application for coverage. Ongoing premium payment must be received within 31 days of the due date or, coverage will automatically be terminated.

Important Note: Although the parent must continue eligibility under the AmeriHealth plan for coverage of the dependent to continue, coverage for the dependent will be issued as stand-alone coverage. This means that all cost-sharing requirements and limitations will apply to the dependent only, and will not be combined with the parent's policy. Covered expenses incurred by the dependent will not contribute to family deductibles and out-of-pocket maximums, nor will family incurred expenses contribute to dependent's deductibles or out-of-pocket maximums.

If the dependent meets the qualifications outlined in this Verification, please complete, sign and return it within 30 days of your receipt along with an enrollment application. A separate application and Verification must be completed for each dependent.

Covered Parent/Subscriber Name: _____ Unique Identifier Number: _____
Dependent Name : _____ Dependent SSN: _____
Group Number: _____ DOB: _____ (mm/dd/yyyy)
I, the dependent listed above: (please check all that apply):

- ☐ Am less than age 30
- ☐ Am unmarried
- ☐ Have no dependent of my own
- ☐ Am a resident of the State of New Jersey
- ☐ Am not a resident of the State of New Jersey, but am enrolled as a full-time student at an accredited public or private institution of higher education
  - Please provide the name of the school _____
  - Please provide the expected date of graduation _____ (mm/yyyy)
  - Please provide a copy of the class schedule signed and stamped by the Registrar
- ☐ I am not actually provided coverage as a named subscriber, insured, enrollee or covered person under any other group health benefits plan or entitled to benefits under Title XVIII of the Social Security Act, Pub.L. 89-97

By signing below, I confirm that the information I have provided is true, accurate, and current.

Signature of Dependent: _____ Date: _____

Please return this completed form (via fax or mail) to the following address within 30 days of receipt of the letter.

Fax this form: (856) 802-3111.

Mail this form to: Nicolle Russo, AmeriHealth, 8000 Midlantic Drive, Suite 333, Mt. Laurel, NJ 08054

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INSTRUCTIONS FOR COMPLETING THE APPLICATION AND VERIFICATION

Initial requests for coverage will require completion of both the application and the verification.

2. An updated verification will be required annually.
3. If no break in coverage occurs, only the verification will be required in subsequent years.
4. To qualify for coverage, the adult child must meet <u>all</u> of the eligibility criteria:
   - o Is a qualified dependent by blood or law of a covered employee/parent/subscriber
   - o The parent/subscriber must be resident of the State of NJ and be covered under an AmeriHealth NJ plan.
   - o Is under 30 years of age
   - o Is not otherwise eligible for coverage within the plan's limiting age provisions
   - o Is unmarried
   - o Has no dependent of his/her own
   - o Is a resident of the State of New Jersey
   - o Is not a resident of the State of New Jersey, but is enrolled as a full-time student at an accredited public or private institution of higher education (**NOTE**: the parent/subscriber must remain a resident of the State of NJ and be covered under an AmeriHealth NJ plan).
     - + If the dependent is a full-time student residing out of state, the member must provide:
       - the name of the school _____
       - the expected date of graduation _____ (mm/yyyy)
       - a copy of the class schedule signed and stamped by the Registrar
   - o The dependent is not actually provided coverage as a named subscriber, insured, enrollee or covered person under any other group health benefits plan or entitled to benefits under Title XVIII of the Social Security Act, Pub.L. 89-97

   Members are eligible to apply for coverage only at the following times:
   - During an Open Enrollment *
   - Within 30 days prior to attainment of limiting age
   - Within 30 days after eligibility for other reasons
   - During special 12-month enrollment – May 12, 2006 through May 11, 2007
6. Please sign and date the application and affidavit – failure to do so will delay processing of your application and coverage cannot be activated. Please be sure all questions have been answered, or we cannot process your application.
7. **The adult child shall be required to pay up to 102% of the cost of the dependent premium. The member will be billed directly for this cost. The initial premium payment is required at the time of application for coverage. Ongoing premium payment must be received within 31 days of the due date or, coverage will automatically be terminated.**

<u>Important Note:</u> Although the parent must continue eligibility under the AmeriHealth plan for coverage of the dependent to continue, coverage for the dependent will be issued as stand-alone coverage. All cost-sharing requirements and limitations will apply to the dependent only, and will not be combined with the parent's policy. Covered expenses incurred by the dependent will not contribute to family deductibles and out-of-pocket maximums, nor will family incurred expenses contribute to dependent's deductibles or out-of-pocket maximums.

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*<u>For Small Group only:</u> **Open enrollment is defined as a 30-day period in each year following the year coverage terminates at the specific age as provided in the plan, beginning on the anniversary date on which coverage terminated.**

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Temporary HINT Supplemental Enrollment Information Form
Implementing P.L. 2005, c. 375

Group & Employee Information

Group Name: _____

Group Number: _____

Employee Name: _____

Employee ID Number: _____

B. Type of Activity (see Important Explanatory Information below)

Date of Event Change – Check all that apply

__/__/__ ☐ Add dependent over the limiting age, but less than 30

__/__/__ ☐ Remove dependent over the limiting age, but less than 30

Reason(s): _____

/ / ☐ Continuation of Coverage pursuant to P.L. 2005, c. 375

Coverage is being effected:

☐ During an Open Enrollment

☐ Within 30 days prior to attainment of limiting age

☐ Within 30 days after eligibility for other reasons

☐ During special 12-month enrollment

Billing: ☐ Direct bill dependent. Please provide the billing address:

Street, Apt. Number: _____

City, State, ZIP Code: _____

C. Over-age Dependent Information

Name (last, first, MI): _____ Sex: ☐ M ☐ F

Birthdate: (MM, DD, YY) __/__/__ SSN: _____

Other Health Coverage: ☐ Yes ☐ No Other Rx Drug Coverage: ☐ Yes ☐ No

Primary Ofc ID Number: _____ Ob/Gyn Ofc ID Number: _____

Current Patient: ☐ Yes ☐ No Current Patient: ☐ Yes ☐ No ☐ N/A

Previous Coverage: ☐ Yes ☐ No

If yes, provide the following information AND submit a copy of the certificate of Creditable Coverage that was issued by the previous carrier, if available:

Effective date of prior coverage: __/__/__

Termination date of prior coverage: /

Name of prior carrier: _____

Prior plan number: _____

D. Signature

_____ _____ _____

Employee Dependent

_____

Date Date

IMPORTANT EXPLANATORY INFORMATION

An adult child may request to continue as a dependent on his or her parent's coverage even after the child reaches the limiting age under the terms of the policy if the adult child:

- is not yet 30 years old
- is unmarried
- has no children
- lives in New Jersey or, if not a New Jersey resident, is a full-time student at an accredited institution of higher education
- is not eligible for Medicare and is not actually covered under another group or individual health plan.

An adult child may make the request to continue as a dependent on his or her parent's coverage either:

- when he or she first reaches the limiting age
- when he or she first becomes eligible for a reason other that reaching the limiting age (for example, the adult child becomes a full-time student in another state, or returns to live in New Jersey after residing elsewhere), or
- during the open enrollment period for the group of which the parent is a member.

In addition, adult children who reached the limiting age under the parent's coverage prior to May 12, 2006 may make an enrollment request at any time from May 12, 2006 through May 11, 2007.

The adult child or covered employee may be required to pay up to 102% of the cost of the dependent premium.