Northeast Regional Office
P.O. Box 26050
Lehigh Valley, PA 18002-6050

ENROLLMENT/CHANGE FORM - NEW JERSEY

- **Please print clearly and in Black Ink**
- **Please print in Capital Letters only**

Planholder Name | Group Plan Number | Division | Class

1. TRANSACTION TYPE:	TYPE OF CHANGE: *(To add or cancel deps. list names in Sec 4.)*				FOR GUARDIAN USE:
☐ New Applicant ☐ Open Enroll ☐ Change in Enroll	☐ Cancel Employee* ☐ Term of Emp. ☐ Other Ins. ☐ Retirement ☐ Other	☐ Add Dependents ☐ Birth ☐ Marriage ☐ Adoption	☐ Cancel Dependents* ☐ Marriage ☐ Divorce ☐ Chg. Student Status ☐ Other	☐ PCP Change ☐ Transfer to COBRA* [See Section 5(g)] ☐ Beneficiary Change	EFF. DATE: EE Cov./$: Dep. Cov./$:

2. CHANGE DATE:

3. EMPLOYEE INFORMATION

Employee Name (Last) | (First) | (MI) | Sex ☐ M ☐ F

Social Security Number | Birth Date (MM DD YYYY) | Primary Care Physician | PCP Access #

Street Address

City | State | ZIP

Home Phone ( ) - | Occupation/Job Title

Are you: ☐ Actively at work ☐ Retired? | New Address? ☐ Yes ☐ No | Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Hours worked per week: | Date of F/T Hire (MM DD YYYY)

4. DEPENDENTS INFORMATION

Spouse Name (First) | (MI) | (Last - if differs from employee's last name) | Sex ☐ M ☐ F

Social Security Number | Birth Date (MM DD YYYY) | Primary Care Physician | PCP Access #

Child Name (First) | (MI) | (Last - if differs from employee's last name) | Student ☐ Y ☐ N | Sex ☐ M ☐ F

Social Security Number | Birth Date (MM DD YYYY) | Primary Care Physician | PCP Access #

Child Name (First) | (MI) | (Last - if differs from employee's last name) | Student ☐ Y ☐ N | Sex ☐ M ☐ F

Social Security Number | Birth Date (MM DD YYYY) | Primary Care Physician | PCP Access #

Child Name (First) | (MI) | (Last - if differs from employee's last name) | Student ☐ Y ☐ N | Sex ☐ M ☐ F

Social Security Number | Birth Date (MM DD YYYY) | Primary Care Physician | PCP Access #

Signature: ______________________________ Date: (MM DD YYYY)

GUARDIAN™ Health Net®

ENROLLMENT/CHANGE FORM - NEW JERSEY

Group Plan Number

Employee's Social Security Number

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

5. ADDITIONAL EMPLOYEE INFORMATION

a) Do you have any dependent children? ☐ Yes ☐ No

b) Are you a resident of New Jersey? ☐ Yes ☐ No Do you maintain residency in another state? ☐ Yes ☐ No

c) If "Yes", what state _________________________ How much time do you spend there each year? ________________________________

d) I previously had coverage during the past 90 days - ☐ Yes ☐ No If "Yes", name of previous carrier ___________________________

Plan # of previous carrier _______________________ Effective Date __________________ Termination Date __________________

e) Which coverage have you selected to be primary in the event expenses are incurred as a result of an automobile related injury?
☐ Auto ☐ Medical

f) I previously refused/waived coverage - ☐ Yes ☐ No

g) I am continuing under a total disability extension - ☐ Yes (attach proof of disability) ☐ No

h) I am continuing under COBRA/Continuation - ☐ Yes ☐ No
*Please attach a copy of the COBRA/Continuation form.

6. ADDITIONAL DEPENDENT INFORMATION

a) If Dependent Child(ren) listed are over the limiting age and attend school on a full time basis, list name and address of school. _______________
____

NOTE: Dependent children may be covered under their parents contract only while unmarried and until they reach the limiting age based on your plans contract.
Unmarried, mentally and physically handicapped dependent children can continue beyond the age limits as long as they remain incapacitated and unmarried.

b) Have you included stepchildren? ☐Yes ☐No If "Yes", indicate name. ____

c) Are they dependent on you for support & maintenance? ☐Yes ☐No

d) Are any dependents currently disabled? ☐Yes ☐No If "Yes", indicate name(s). ______________________________________
(Pursuant to Federal Law, this information will not be used to determine eligibility for medical coverage.)

e) Do any dependents reside at a different address than indicated above? ☐Yes ☐No If "Yes," list name and address. ___________________
____

7. COVERAGE SELECTION

Please check one: ☐ HMO ☐ Point of Service (POS)

For: ☐ Employee Only ☐ Employee and Spouse ☐ Employee and Child(ren) ☐ Employee, Spouse and Child(ren)

8. Is your spouse employed? ☐ Yes ☐ No If "Yes", name and address of employer:

9. Do you or your dependents have other health insurance under a group plan, HMO or Medicare? ☐ Yes ☐ No If "Yes", complete this section

Name of Person	Employer	Policy #

Insurance Company Name & Address	Medicare
	Part ☐A ☐B

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
The information provided on this form is true and correct to the best of my knowledge, and I accept the provisions on this form which I have read and understand.

Signature: ____ Date: (MM DD YYYY)

DECLARATION, 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 on this form are true and complete. I understand that the information shall form the basis upon which I may be included for coverage under the group plan.

I understand that:

a) the coverage applied for will not take effect unless:
   - after review of this Enrollment Form, Physicians Health Services of New Jersey, Inc. accepts it;
   - the first premium has been paid to Physicians Health Services of New Jersey, Inc.; 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 for a waiver of the active requirement.

b) no person, except an officer of Physicians Health Services of New Jersey, Inc. has authority to: determine whether a certificate shall be issued based on this Enrollment Form; waive or modify any of the provisions of the Enrollment Form or any of the Physicians Health Services of New Jersey, Inc. by any statement or promise pertaining to any certificates 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 Physicians Health Services of New Jersey. Inc.

Unless I request otherwise in writing, I understand that by signing this form when I file a claim, Physicians Health Services of New Jersey, Inc. 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 Physicians Health Services of New Jersey, Inc.'s service area. I understand that if I omit or falsify any statement on this enrollment form, Physicians Health Services of New Jersey, Inc. can cancel my coverage as of the original effective date.

Any person who includes any false or misleading information on an application or enrollment/change form for health benefits plan is subject to criminal and civil penalties.

Note: A person who was covered under Creditable Coverage has a right to request a certificate from the prior plan or issuer to demonstrate that they were covered under Creditable Coverage. If necessary, Physicians Health Services of New Jersey, Inc. will assist the person in obtaining a certificate from the prior plan or issuer.

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 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 members 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 Physicians Health Services of New Jersey, Inc., 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.
7. Employee acknowledges that Physicians Health Services of New Jersey, Inc.'s participating providers, including all primary care physicians, are independent contractors and are not agents or employees of Physicians Health Services of New Jersey, Inc.

Authorization

1. I authorize the sources stated on the reverse side to give Physicians Health Services of New Jersey, Inc., 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 Physician Health Services of New Jersey, Inc. has taken in reliance on the authorization. I understand this authorization will not be valid after 20 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.

ADDITIONAL INFORMATION

Open Enrollment: Unless the member moves his or her place of residence outside of the HMO's designated service area, a person's choice of health benefits "generally" will determine his or her coverage until the next annual open enrollment period, regardless of the continued availability of a particular health care provider who contracts with the HMO.

Disclosure of Provider Compensation Arrangements: Compensation to providers authorized to furnish health care services to our members may be based on a variety of payment mechanisms. Your primary care physician may receive a fee for service payments, salary, or capitation payments (a set dollar amount per patient) for services they provide.

Different providers in our network have agreed to be paid in different ways by us. Your provider may be paid each time they treat you (fee for service) or may be paid a set fee each month for each member whether or not the member actually receives services (capitation) or may receive a salary.

Financial incentive arrangements such as withholds and/or bonuses are used with these various types of payment mechanisms.

These payment methods may include financial incentive agreements to pay some providers more (bonuses) or less (withholds) based on many factors: member satisfaction, quality of care, and control of costs and use of services among them.

If you desire additional information about how our primary care physicians or any other providers in our network are compensated, please call us at 1-800-441-5741 or write: Physicians Health Services of New Jersey
One Far Mill Crossing
P.O. Box 904
Shelton, CT 06484-0944