

SECTION II: SPECIFICATIONS FOR COVERAGE

HMO

Copayment: \$2 \$5 \$10 \$15 \$20 \$30
 Plan: Basic Premium Plus
 Standard
 Prescription: \$5/\$10 NM \$5/\$10 w/mail \$15
 Select Drug Program:
 \$5/\$15/\$25 \$10/\$20/\$35
 \$5/\$20/\$35 \$15/\$25/\$35
 Vision: \$35 \$100

OPEN ACCESS

Copayment: \$10 \$15
 Plan: Open Access Open Access Plus
 Option: 4 (Open Access Plus only)
 Prescription: \$5/\$10 NM \$5/\$10 w/mail \$15
 Vision: \$35 \$100

POS

Copayment: \$2 \$5 \$10 \$15 \$20 \$30
 Plan: Basic Premium Plus
 Option: 1 2 3 4 5 6 7
 Standard
 Prescription: \$5/\$10 NM \$5/\$10 w/mail \$15
 Select Drug Program:
 \$5/\$15/\$25 \$10/\$20/\$35
 \$5/\$20/\$35 \$15/\$25/\$35
 Vision: \$35 \$100

PPO

Copayment: \$5 \$10 \$20 \$30
 Plan: C D \$0 Hospital Copayment
 In-Network

Standard

Prescription: Integrated \$5/\$10 \$15
 Select Drug Program:

\$5/\$15/\$25 \$10/\$20/\$35
 \$5/\$20/\$35 \$15/\$25/\$35

Vision: \$35 \$100

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

CMM

Plan: A B C D E
 Deductible: \$150 \$250 \$500 \$1,000

Standard

Prescription: Integrated \$5/\$10
 Not available with A

Select Drug Program:

\$5/\$15/\$25 \$10/\$20/\$35
 \$5/\$20/\$35 \$15/\$25/\$35

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(s), 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 [] Dual Contract POS
 [] Other _____
- Has your firm been uninsured for 3 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/Certificate 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 continuations.

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

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

7. To the best of your knowledge:

7a. Are any employees or dependents presently incapacitated? [] Yes [] No

7b. 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

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 AmeriHealth HMO, Inc. and AmeriHealth Insurance Company of New Jersey to make or modify any request or application for insurance or to bind AmeriHealth HMO, Inc. and AmeriHealth Insurance Company of New Jersey 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 AmeriHealth HMO, Inc. and/or AmeriHealth Insurance Company of New Jersey. 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.



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