



## AmeriHealth 51+ Group Enrollment Form

### Checklist for New Submissions – 51+

**For All New groups, 51+ employees:**

- This completed AmeriHealth Group Enrollment Form
- Copy rate quote
- Enrollment form for each enrolling employee (Note: Product selection by subscriber is required)
- First month's premium – MUST BE CORPORATE (not personal) CHECK
- Broker of Record letter, on enrolling company's letterhead
- Waivers, if applicable

### Group Enrollment Information

Group Name:	Group Contact:
Address:	Title:
	Industry Type: /SIC Code
City:	New Hire Waiting: <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 <input type="checkbox"/> Other
State: Zip:	# Total Employees:
Phone:	# Employees in AmeriHealth HMO/POS:
Effective Date: Tax ID:	# Employees in AmeriHealth PPO/CMM:
Check Amount \$	# Employees in other carriers:
Prior Carrier:	# Employees waiving coverage:
Employer Participation:	
Group's E-mail address:	Is group all-AmeriHealth? <input type="checkbox"/> Yes <input type="checkbox"/> No

### Standard 51+ Plans

<u>HMO/POS</u>	<u>Standard Drug</u>	<u>Select Drug</u>	<u>Deductible/Copayment Drug</u>	<u>Vision Rider</u>
<input type="checkbox"/> AmeriHealth 2	<input type="checkbox"/> \$5	<input type="checkbox"/> \$5/\$10/\$25	<input type="checkbox"/> \$100/\$15/\$15	<input type="checkbox"/> \$35 Biennial Benefit
<input type="checkbox"/> AmeriHealth 5	<input type="checkbox"/> \$10	<input type="checkbox"/> \$5/\$10/\$35 *	<input type="checkbox"/> \$100/\$15/\$25	<input type="checkbox"/> \$100 Biennial Benefit
<input type="checkbox"/> AmeriHealth 10	<input type="checkbox"/> \$15	<input type="checkbox"/> \$5/\$10/\$50 *	<input type="checkbox"/> \$200/\$15/\$15	
<input type="checkbox"/> AmeriHealth 15	<input type="checkbox"/> \$1/\$3	<input type="checkbox"/> \$5/\$15/\$25	<input type="checkbox"/> \$200/\$15/\$25	
<input type="checkbox"/> AmeriHealth 20	<input type="checkbox"/> \$2/\$6	<input type="checkbox"/> \$5/\$15/\$35 *	<input type="checkbox"/> \$100/\$15/\$25/\$35	
<input type="checkbox"/> AmeriHealth Select 10	<input type="checkbox"/> \$4/\$8	<input type="checkbox"/> \$5/\$15/\$50 *	<input type="checkbox"/> \$200/\$15/\$25/\$35	
<input type="checkbox"/> AmeriHealth Select 15	<input type="checkbox"/> \$5/\$20	<input type="checkbox"/> \$5/\$20/\$35		
<input type="checkbox"/> AmeriHealth \$20 Premium	<input type="checkbox"/> \$6/\$10	<input type="checkbox"/> \$5/\$20/\$50 *		
<input type="checkbox"/> AmeriHealth \$20 Premium Select	<input type="checkbox"/> \$8/\$14	<input type="checkbox"/> \$10/\$20/\$35		
<input type="checkbox"/> AmeriHealth \$30	<input type="checkbox"/> \$10/\$15	<input type="checkbox"/> \$10/\$20/\$50 *		
<input type="checkbox"/> AmeriHealth \$30 Select	<input type="checkbox"/> \$10/\$20	<input type="checkbox"/> \$5/\$10/50% *		
<input type="checkbox"/> AmeriHealth \$30 Premium Select	<input type="checkbox"/> 50%/50%	<input type="checkbox"/> \$5/\$15/50% *		
<input type="checkbox"/> POS Option A		<input type="checkbox"/> \$5/\$20/50% *		
<input type="checkbox"/> POS Option B		* Available for 100+ groups only		
<input type="checkbox"/> POS Option C		<b>Contraceptive Coverage Under The Prescription Drug Program:</b>		
<input type="checkbox"/> POS Option D		<input type="checkbox"/> Included	<input type="checkbox"/> Excluded	
<input type="checkbox"/> POS Option E		<b>Drug Retail Dispensing:</b>		
<input type="checkbox"/> Student/Dependent Ages:		<input type="checkbox"/> 90 Day/3 Copays or Coinsurance (For Deductible/Copayment Program, Deductible must be met first)		
<input type="checkbox"/> 19/23 <input type="checkbox"/> 23/23 <input type="checkbox"/> Other ___/___		<input type="checkbox"/> Other (Rx Benefit Exception Required):		
<input type="checkbox"/> End of Month <input type="checkbox"/> End of Year				

**Standard 51+ Plans (Cont'd)**

<b>PPO</b>	<b>Standard Drug</b>	<b>Select Drug</b>	<b>Deductible/Copayment Drug</b>	<b>Vision Rider</b>
<input type="checkbox"/> PPO 5	<input type="checkbox"/> \$1/\$3 *	<input type="checkbox"/> \$5/\$10/\$25	<input type="checkbox"/> \$100/\$15/\$15	<input type="checkbox"/> \$35
<input type="checkbox"/> PPO 10	<input type="checkbox"/> \$2/\$6 *	<input type="checkbox"/> \$5/\$10/\$35 *	<input type="checkbox"/> \$100/\$15/\$25	<input type="checkbox"/> \$100
<input type="checkbox"/> PPO 15	<input type="checkbox"/> \$4/\$8 *	<input type="checkbox"/> \$5/\$10/\$50 *	<input type="checkbox"/> \$200/\$15/\$15	<input type="checkbox"/> \$200
<input type="checkbox"/> PPO 20	<input type="checkbox"/> \$5/\$10	<input type="checkbox"/> \$5/\$15/\$25	<input type="checkbox"/> \$200/\$15/\$25	<input type="checkbox"/> \$250
<input type="checkbox"/> PPO 205 **	<input type="checkbox"/> \$8/\$15*	<input type="checkbox"/> \$5/\$15/\$35 *	<input type="checkbox"/> \$100/\$15/\$25/\$35	
<input type="checkbox"/> PPO 210 **	<input type="checkbox"/> 50%/50%	<input type="checkbox"/> \$5/\$15/\$50 *	<input type="checkbox"/> \$200/\$15/\$25/\$35	
<input type="checkbox"/> PPO 215 **		<input type="checkbox"/> \$5/\$20/\$35		<input type="checkbox"/> Biennial Benefit (Standard)
<input type="checkbox"/> PPO 220 **		<input type="checkbox"/> \$5/\$20/\$50 *		<input type="checkbox"/> Annual Benefit
<input type="checkbox"/> PPO 310		<input type="checkbox"/> \$10/\$20/\$35		
<input type="checkbox"/> PPO 320		<input type="checkbox"/> \$10/\$20/\$50 *		
<input type="checkbox"/> PPO 5/15/70%		<input type="checkbox"/> \$5/\$10/50% *		
<input type="checkbox"/> PPO 10/20/70%		<input type="checkbox"/> \$5/\$15/50% *		
<input type="checkbox"/> PPO 15/25/70%		<input type="checkbox"/> \$5/\$20/50% *		
<input type="checkbox"/> PPO 20/30/70%				
<input type="checkbox"/> PPO 520/80%/50%				
<input type="checkbox"/> PPO 1020/80%/50%				
<input type="checkbox"/> PPO 2020/80%/50%				
<input type="checkbox"/> PPO 2520/80%/50%				
<b>** Only available to existing groups currently enrolled in a "200" series option</b>				
<b>Student/Dependent Ages:</b>				
<input type="checkbox"/> 19/23 <input type="checkbox"/> 23/23 <input type="checkbox"/> Other ____/____				
<input type="checkbox"/> End of Month <input type="checkbox"/> End of Year				
<b>* Available for 100+ groups only</b>				
<b>Contraceptive Coverage Under The Prescription Drug Program:</b>				
<input type="checkbox"/> Included <input type="checkbox"/> Excluded				
<b>Drug Retail Dispensing:</b>				
<input type="checkbox"/> 90 Day/3 Copays or Coinsurance (For Deductible/Copayment Program, Deductible must be met first)				
<input type="checkbox"/> Other (Rx Benefit Exception required): _____				

**Traditional Med**

\$200 Deductible

\$250 Deductible

\$500 Deductible

\$1,000 Deductible

**Freestanding Prescription Drug**

<b>Standard Drug</b>	<b>Select Drug</b>	<b>Deductible Copayment Drug</b>
<input type="checkbox"/> \$1/\$3	<input type="checkbox"/> \$5/\$10/\$25	<input type="checkbox"/> \$100/\$15/\$15
<input type="checkbox"/> \$2/\$6	<input type="checkbox"/> \$5/\$10/\$35 *	<input type="checkbox"/> \$100/\$15/\$25
<input type="checkbox"/> \$4/\$8	<input type="checkbox"/> \$5/\$10/\$50 *	<input type="checkbox"/> \$200/\$15/\$15
<input type="checkbox"/> \$2/\$10	<input type="checkbox"/> \$5/\$15/\$25	<input type="checkbox"/> \$200/\$15/\$25
<input type="checkbox"/> \$5/\$10	<input type="checkbox"/> \$5/\$15/\$35 *	<input type="checkbox"/> \$100/\$15/\$25/\$35
<input type="checkbox"/> \$5/\$15	<input type="checkbox"/> \$5/\$15/\$50 *	<input type="checkbox"/> \$200/\$15/\$25/\$35
<input type="checkbox"/> \$5/\$20	<input type="checkbox"/> \$5/\$20/\$35	
<input type="checkbox"/> \$6/\$10	<input type="checkbox"/> \$5/\$20/\$50 *	
<input type="checkbox"/> \$8/\$14	<input type="checkbox"/> \$10/\$20/\$35	
<input type="checkbox"/> \$10/\$20	<input type="checkbox"/> \$10/\$20/\$50 *	
<input type="checkbox"/> 50%/50%	<input type="checkbox"/> \$5/\$10/50% *	
	<input type="checkbox"/> \$5/\$15/50% *	
	<input type="checkbox"/> \$5/\$20/50% *	
<b>* Available for 100+ groups only</b>		
<b>Contraceptive Coverage Under The Prescription Drug Program:</b>		
<input type="checkbox"/> Included <input type="checkbox"/> Excluded		
<b>Drug Retail Dispensing:</b>		
<input type="checkbox"/> 90 Day/3 Copays or Coinsurance (For Deductible/Copayment Program, Deductible must be met first)		
<input type="checkbox"/> Other (Rx Benefit Exception required): _____		

X \_\_\_\_\_  
Selling Agent Signature

X \_\_\_\_\_  
Primary Broker

By signing, I acknowledge that I have completed all documents required by AmeriHealth, and that if any required documentation is not included with this submission, the entire case will be returned to me.