AmeriHealth NEW JERSEY

Group Administrator to submit this completed application to:
Ahnjgroupsetup@amerihealth.com

AmeriHealth New Jersey SEH Dental Application

Application for a small group employer dental policy

☐ New Policy ☐ Change in Policy ☐ Requested Effective Date:____/____/____

Note: The Effective Date will be on or after the date AmeriHealth New Jersey approves the application.

For AmeriHealth New Jersey use only
AmeriHealth Insurance Company of New Jersey
Group Number:_____

Section I: Policy holder information

1. Policyholder (full legal name of Company):

2. Tax Identification Number:

3. Main Address
   Street:_____
   City:_____ State:_____ Zip Code:_____
   Mailing Address
   Street:_____
   City:_____ State:_____ Zip Code:_____
   Telephone: (_____)_____ Fax: (_____)_____
   Name of Group Administrator: _____ Email Address: _____

4. Type of Organization: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Other (explain)

5. Nature of business: (specify) | SIC Code:

6. Number of eligible employees in your company:_____
   Please Refer to the New Jersey Small Employer Certification for the definition of an eligible employee.

7. Number of eligible employees to be insured:

Section II: AmeriHealth New Jersey Pediatric Dental Options – Required

☐ SEH Pediatric Dental ☐ SEH Pediatric Dental with Adult Preventative ☐ SEH Family Dental

The Patient Protection and Affordable Care Act (PPACA) allows for plans outside of the Health Insurance Marketplace and the Small Business Health Options Program (SHOP) to issue coverage without pediatric dental benefits as long as the applicant provides reasonable assurance that an exchange-certified Stand-Alone Dental Plan (SADP) covering the pediatric dental benefits has been purchased elsewhere. To help you meet this requirement, AmeriHealth New Jersey is offering pediatric dental coverage through our SEH Pediatric Dental, SEH Pediatric Dental with Adult Preventative, and SEH Family Dental plans.

☐ Attest to having pediatric dental coverage elsewhere

If you did not select one of the stand-alone pediatric dental plans listed above, we require one of the following options as proof of coverage in order to receive reasonable assurance from you.

☐ Option 1 – Please provide supporting documentation such as:

- Copy of dental policy document, which includes specific reference to coverage of pediatric dental benefit; OR
- Welcome letter from dental carrier, which includes specific reference to coverage of pediatric dental benefit; OR
- Current invoice from dental carrier, which includes specific reference to coverage of pediatric dental benefit;

For new and retention business, please submit supporting documentation to: AHNJdentalattestation@amerihealth.com or fax to 609-662-2630.

☐ Option 2 – Please provide the contact information of your pediatric dental carrier for proof of coverage by completing the section below.

Dental Carrier Name:	Dental Product Name:
Effective date for current Pediatric Dental coverage:____/____/____	Group Dental Policy Number:

Section III: Agent / Producer Information	
Agent/Broker Name:	
Section IV: Signature	
THE APPLICANT REPRESENTS that: by signing this application, he/she agrees that the group dental insurance described above will become effective upon acceptance of this application by AmeriHealth New Jersey. Applicant further acknowledges that no coverage will be effective before the date determined by AmeriHealth New Jersey and only if the first Premium has been paid. If this application is accepted, it becomes a part of the insurance contract between Applicant and AmeriHealth New Jersey. If this application is not accepted, any Premium advanced by the Applicant will be refunded. All statements made by the policyholder or by the persons insured shall be deemed representations and not warranties, and that no statement made by any person insured shall avoid the insurance or reduce benefits thereunder unless contained in a written instrument signed by the person insured. If errors or omissions in this application are discovered by AmeriHealth New Jersey, it is authorized to amend this application by noting the changes on this form, and the acceptance, evidenced by Premium payment, of any Policy issued on this application, so amended, shall constitute a ratification of any such changes or amendments. Upon policy renewal date, payment of the renewal premium will confirm acceptance of that renewal for the subsequent rate period. No agent or broker has the right to accept this application or bind coverage. Any first premium or application submitted to AmeriHealth New Jersey or its sales personnel by a non-appointed producer must be accompanied by completed appointment paperwork or it will be returned to the non-appointed producer. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. The applicant by signing this application certifies that all statements made by the applicant are to be true and complete to the best of the applicant's knowledge and belief.	
Dated at:	Dated 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 statement and answers given in this application (i.e. crossed out, whited-out, erased, etc.), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.

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