



SECTION II: SPECIFICATIONS FOR COVERAGE

HEALTH BENEFITS:

Indemnity Plan:  A  B  C  D  E Deductible \$ \_\_\_\_\_

Remarks: \_\_\_\_\_

PPO Plan: Please indicate PPO Plan being elected: \_\_\_\_\_

HMO Plan: Please write in the HMO plan code: \_\_\_\_\_ (Example 1NJS)

POS: Please write in the POS plan code: \_\_\_\_\_ (Example 5NJS)

PRESCRIPTION DRUG BENEFITS:

Indemnity Plan	<input type="checkbox"/> Card - \$5 Copay Generic \$10 Copay Brand	<input type="checkbox"/>	\$5 Copay Generic <u>Card/ \$10 Copay Brand</u> Mail Order \$0 Copay Generic Combination \$5 Copay Brand
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PPO Plan	<input type="checkbox"/> Card - \$5 Copay Generic \$10 Copay Brand	<input type="checkbox"/>	\$5 Copay Generic <u>Card/ \$10 Copay Brand</u> Mail Order \$0 Copay Generic Combination \$5 Copay Brand
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HMO Plan: Base prescription benefit included with medical. \$15 Copay Prescription Card.  
Optional rider will replace the base prescription benefit.

<input type="checkbox"/> Card - \$5 Copay Generic \$10 Copay Brand <b>(G1)</b>	<input type="checkbox"/>	\$5 Copay Generic <u>Card/ \$10 Copay Brand</u> <b>(G3)</b> Mail Order \$0 Copay Generic Combination \$5 Copay Brand
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POS Plan: Base prescription benefit included with medical: Base prescription copay for prescriptions dispensed in-network mirrors base medical copay for office visits in-network, i.e., \$5, \$10, \$15 and \$20 office visit copay plans will have \$5, \$10, \$15 and \$20 prescription copays respectively. Reimbursement for prescriptions dispensed out-of-network, according to plan deductible and coinsurance.

Optional Rider will replace the base prescription benefit

<input type="checkbox"/> Card - \$5 Copay Generic \$10 Copay Brand <b>(G7)</b>	<input type="checkbox"/>	\$5 Copay Generic <u>Card/ \$10 Copay Brand</u> <b>(G8)</b> Mail Order \$0 Copay Generic Combination \$5 Copay Brand
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Card - \$5 Copay Prescription Card for in-network use and reimbursement to plan deductible and coinsurance when dispensed out-of-network. **(H7)**

Card - \$10 Copay Prescription Card for in-network use and reimbursement to plan deductible and coinsurance when dispensed out-of-network. **(FN)**

Card - \$15 Copay Prescription Card for in-network use and reimbursement to plan deductible and coinsurance when dispensed out-of-network. **(FZ)**

Card - \$20 Copay Prescription Card for in-network use and reimbursement to plan deductible and coinsurance when dispensed out-of-network. **(H9)**

**DEPENDENT ELIGIBILITY: PLEASE NOTE:** (All medical coverage in force must carry the same dependent eligibility).

Base Benefit: Dependent children covered to age 19; 23 if full-time student under Indemnity, PPO, HMO, and POS Medical/Prescription Plans.

Optional rider: (86) Dependents covered to age 20; 26 if full-time student.  Yes  No

**OTHER OPTIONAL RIDERS** as may become available (Please list): \_\_\_\_\_ paired with \_\_\_\_\_ Plan  
 \_\_\_\_\_ paired with \_\_\_\_\_ Plan  
 \_\_\_\_\_ paired with \_\_\_\_\_ Plan  
 \_\_\_\_\_ paired with \_\_\_\_\_ Plan

**SECTION III: ALL QUESTIONS MUST BE ANSWERED**

1a. Is there any insurance plan:  
 ● now in force and to be continued?  Yes  No  
 ● currently being applied for?  Yes  No  
 If yes, give a description of the plan and name of insurance carrier(s) \_\_\_\_\_

b. 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  POS  PPO  Other \_\_\_\_\_

c. Has your firm been uninsured for 3 or more months prior to application?  Yes  No

2. What forms of insurance are now or were in force?  Health Benefits  Prescription Drugs  
 (Attach copies of Booklet/Certificate and most recent Billing Statement)

3. Are extended benefits provided in case of termination of health benefits?  Yes  No

4. 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

5. To the best of your knowledge:

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

b. Are any dependent children incapable of self-support due to a physical or mental disability?  Yes  No

Additional space to explain if items 1 a,b,c were answered "yes". Refer to the question number and give details including names, where appropriate.

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**SECTION IV: AGENT/PRODUCER INFORMATION**

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1) Agent \_\_\_\_\_

2) Agent Address \_\_\_\_\_

3) Phone Number \_\_\_\_\_ 4) Fax Number \_\_\_\_\_

5) Agent/Agency Code \_\_\_\_\_

6) Licensed with Guardian (?) \_\_\_\_\_ With PHS (?) \_\_\_\_\_

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**SECTION V: SIGNATURE**

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It is understood that only full-time employees are eligible. It is further understood that no agent has power on behalf of Guardian or Health Net of New Jersey, Inc. to make or modify any request or application for insurance or to bind Guardian or Health Net of New Jersey, Inc. 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 Guardian or Health Net of New Jersey, Inc. 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 knowingly files a statement of claim, application for insurance, enrollment form, or certification containing any false or misleading information may be 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, white-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.