AmeriHealth NEW JERSEY

Verification of requirements

The AmeriHealth contract states that a dependent may be covered to age 31 if he or she meets certain criteria:

- the dependent's parent remains covered by the plan;
- the employer retains coverage with AmeriHealth;
- contributions are made by or on behalf of the dependent.

To request continued coverage, a verification of requirements form must be completed indicating that all of the criteria have been met.

For each eligible over-age dependent, the AmeriHealth premium rate* will be calculated at 67.4% of the single rate for the same plan of benefits in which the parent is actively enrolled. **Please contact your AmeriHealth Marketing Representative for the exact rate for over-age dependents.** An over-age dependent must include a check for this amount when he or she mails in the completed HINT application. AmeriHealth will bill the over-age dependent directly. Ongoing premium payment must be received within 30 days of the due date or, coverage will automatically be terminated.

Note: Although the parent must continue eligibility under the AmeriHealth plan for coverage of the dependent to continue, coverage for the dependent will be issued as stand-alone coverage. This means that all cost-sharing requirements and limitations will apply to the dependent only and will not be combined with the parent's policy. Covered expenses incurred by the dependent will not contribute to family deductibles and out-of-pocket maximums, nor will family-incurred expenses contribute to dependent's deductibles or out-of-pocket maximums.

If the dependent meets the qualifications outlined in this verification, please complete, sign and return it within 30 days of your receipt along with a HINT application. A separate HINT application and verification of requirements form must be completed for each dependent.

Covered parent/Subscriber name: _____ Identifier number: _____
Dependent name : _____ Dependent SSN: _____
Group number: _____Date of birth: _____ (mm/dd/yyyy) Phone number: _____
I, the dependent listed above: (please check all that apply):

- ☐ am under age 31
- ☐ am unmarried
- ☐ have no dependent of my own
- ☐ have proof of prior creditable coverage
- ☐ am a resident of the State of New Jersey

or

- ☐ am not a resident of the State of New Jersey, but am enrolled as a full-time student at an accredited public or private institution of higher education.
  - Name of the school _____
  - Expected date of graduation _____ (mm/yyyy)

  Please provide a copy of the class schedule signed and stamped by the registrar.
- ☐ am not provided coverage as a named subscriber, insured, enrollee or covered person under any other group health benefits plan, nor am I entitled to benefits under Title XVIII of the Social Security Act, Pub.L. 89-97.

By signing below, I confirm that the information I have provided is true, accurate, and current.

Signature of dependent: _____ Date:_____

Please mail this completed form to the following address within 30 days of receipt:
Mail form to: AmeriHealth, Attn: Sales-OAD, 8000 Midlantic Drive, Suite 333, Mt. Laurel, NJ 08054

PLEASE DO NOT SEND THIS FORM TO ENROLLMENT.

*The premium rate includes the 102% factor that is noted on the HINT application.