52530

AmeriHealth

2025 Benefits & Information Change Form

Answering questions marked optional is your choice. You can't be denied coverage because you don't fill them out.

Name of Plan you are enrolling in:

Name:	**Medicare Number:**

Home Phone Number: (_____) _____ - _____

Email Address (optional): _____

By voluntarily giving AmeriHealth my phone number (including my mobile number) and/or email address, I authorize AmeriHealth Insurance Company of New Jersey and its affiliates (collectively AmeriHealth) to send me information/data about AmeriHealth, including, but not limited to, information about my account and other insurance products and services. AmeriHealth may contact me via email, automated text, and/or phone call. For text, message and data rates may apply. Not required to purchase goods and services from AmeriHealth. Text STOP to stop and HELP for help. Terms and conditions at www.myhelpsite.net/amerihealth. Any information provided by me to AmeriHealth is subject to the AmeriHealth Privacy Policy.

Permanent Street Address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a P.O. Box may be considered your permanent residence address.)**:**

Street Address: City: State: ZIP Code:

Mailing Address (Only if different from your permanent residence address. P.O. Box is allowed):

Street Address: City: State: ZIP Code:

Please fill out the following: I am currently a member of the _____ plan in AmeriHealth with a monthly premium of $_____. I would like to change to the plan indicated below. I understand that this plan has different health benefits and a different monthly premium, as shown below.

Choose **ONE** of the plans below by placing a check mark ✓ in the box ❑. For more information on coinsurance, copayments, deductibles, and limitations for each plan, see your Summary of Benefits and/or Evidence of Coverage.

❑ AmeriHealth Medicare Core PPO (001)	$0.00
❑ AmeriHealth Medicare Enhanced PPO (002)	$30.40
❑ AmeriHealth Medicare Secure PPO (003)	$0.00
❑ AmeriHealth Medicare Ultimate PPO (004)	$0.00

Name of chosen Primary Care Physician (PCP), clinic or health center (optional)**:**	**Physician Code No. / Group ID** (optional)**:**

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply. (optional)

❑ No, not of Hispanic, Latino/a, or Spanish origin
❑ Yes, Puerto Rican
❑ Yes, another Hispanic, Latino/a, or Spanish origin
❑ Yes, Mexican, Mexican American, Chicano/a
❑ Yes, Cuban
❑ **I choose not to answer**

What's your race? Select all that apply. (optional)

❑ American Indian or Alaska Native

Asian:
- ❑ Asian Indian
- ❑ Chinese
- ❑ Filipino
- ❑ Japanese
- ❑ Korean
- ❑ Vietnamese
- ❑ Other Asian

❑ Black or African American

Native Hawaiian and Pacific Islander:
- ❑ Guamanian or Chamorro
- ❑ Native Hawaiian
- ❑ Samoan
- ❑ Other Pacific Islander

❑ White
❑ **I choose not to answer**

Answering questions marked optional is your choice. You can't be denied coverage because you don't fill them out.

What is your gender? Select one. (optional)

❑ Woman
❑ Man
❑ Non-binary
❑ I use a different term:
❑ **I choose not to answer.**

Answering questions marked optional is your choice. You can't be denied coverage because you don't fill them out.

Which of the following best represents how you think of yourself? Select one. (optional)

- ❑ Lesbian or gay
- ❑ Straight, that is, not gay or lesbian
- ❑ Bisexual
- ❑ I use a different term:
- ❑ I don't know
- ❑ **I choose not to answer.**

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format: ❑ Braille ❑ Large Print ❑ Audio CD ❑Data CD

Please contact AmeriHealth at 1-800-898-3492 if you need information in another format or language than what is listed above. Our office hours are seven days a week, 8 a.m. to 8 p.m. TTY/TDD users should call 711. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail.

Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty you have or may owe) by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board Check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount witheld from your Social Security benefit check or be billed directly by Medicare or the Railroad Retirement Board. Do NOT pay AmeriHealth the Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs, including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY/TDD users should call 1-800-325-0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help. If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option: ❑ Get a bill ❑ Pay directly on amerihealth.com

❑ EFT from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name:

Bank routing number: | | | | | | | | | |

Bank account number: | | | | | | | | | | | | |

Account type: ❑ Checking ❑ Savings

❑ Automatic deduction from your monthly Social Security or RRB benefit check.

I get monthly benefits from: ❑ Social Security ❑ RRB

(The Social Security deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

STOP Please Read This Important Information.

Please Read and Sign Below:

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that AmeriHealth Medicare PPO will release my information, including my prescription drug event data to Medicare, which may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand that people with Medicare aren't covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date AmeriHealth Medicare PPO coverage begins, using services in network can cost less than using services out of network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, AmeriHealth Medicare PPO provides refunds for all covered benefits, even if I get services out of network. Without authorization, **NEITHER MEDICARE NOR AMERIHEALTH MEDICARE PPO WILL PAY FOR THE SERVICES.**

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with AmeriHealth, he/she may be paid based on my enrollment in AmeriHealth Medicare PPO. AmeriHealth Medicare coverage issued by AmeriHealth Insurance Company of New Jersey.

AmeriHealth offers PPO Medicare Advantage plans with a Medicare contract. Enrollment in AmeriHealth PPO Medicare Advantage plans depends on contract renewal. You must continue to pay your Medicare Part B premium.

Signature:	**Today's Date:** (_____ /_____ /_____) **(M M / D D / Y Y Y Y)**

If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

Phone Number: ( ) _____ - _____ Relationship to Enrollee: _____

For individuals ~~helping~~ enrollee with completing this form only:

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name: _____

Relationship to enrollee: _____

Signature: _____

For agents and brokers only:

Name of staff member/agent/broker (if assisted in enrollment): _____

Plan ID #: _____

Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

Agent number (NIPR/NPN): _____