



Verification of Requirements

The AmeriHealth contract states that a dependent may be covered to age 30 if he or she meets certain criteria:

- The dependent’s parent remains covered by the plan, and
- the employer retains coverage with AmeriHealth, and
- Contributions are made by or on behalf of the dependent.

In order to request continued coverage, AmeriHealth requires a verification form be completed indicating that all of the criteria have been met.

Payment. The dependent shall be required to pay up to 102% of the dependent premium. The dependent will be billed directly for this cost. The initial premium payment is required at the time of application for coverage. Ongoing premium payment must be received within 31 days of the due date or, coverage will automatically be terminated.

Important 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 an enrollment application. A separate application and Verification must be completed for each dependent.

Covered Parent/Subscriber Name: _____ Unique Identifier Number: _____

Dependent Name : _____ Dependent SSN: _____

Group Number: _____ DOB: _____ (mm/dd/yyyy)

I, the dependent listed above: (please check all that apply):

- Am less than age 30
- Am unmarried
- Have no dependent of my own
- Am a resident of the State of New Jersey
- 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
 - Please provide the name of the school _____
 - Please provide the expected date of graduation _____ (mm/yyyy)
 - Please provide a copy of the class schedule signed and stamped by the Registrar
- I am not actually provided coverage as a named subscriber, insured, enrollee or covered person under any other group health benefits plan or 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 return this completed form (via fax or mail) to the following address within 30 days of receipt of the letter.

Fax this form: (856) 802-3111.

Mail this form to: Nicolle Russo, AmeriHealth, 8000 Midlantic Drive, Suite 333, Mt. Laurel, NJ 08054