

COUNTY: _____



Expected Enrollment Date: _____

(For Internal Use Only)

HMO PLAN SELECTION FORM



1. Please fill in the Information Below

NJ FamilyCare Number: _____

Head of Household: _____

Address: _____

Soc. Security No.: _____

Household Phone No. _____

Language Spoken: _____

City/State/ZIP: _____

Family Members Information:

Last Name	First	Date of Birth	Sex	Social Security Account Number
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

2. Guardian Information (If Applicable) Authorized Person/Guardian (if other than applicant).

Name	Address	Authorized Person/Guardian's Telephone Number
_____	_____	_____

3. Choose Your Health Plan

Select the name of the HMO plan of your choice. *Please see HMO brochure for more information.*

- Amerigroup
- AmeriChoice of NJ
- Horizon NJ Health
- University Health Plans

4. Sign your HMO Plan Selection Form.

Please sign and date below. *Before signing, read Statement of Understanding. Signing below means: you have read and understand all pages of this form including the Statement of Understanding; and you give us permission to give all information obtained here and in our interview (by phone or in person) to your health plan.*

Signature / Relationship to Family Members	Date	Witness
_____	_____	_____

5. If We Need to Reach You ... Please give us the best phone number to reach you during the day should we need to call you about your choice.

Area Code Daytime Phone Number
 () _____

6. Next Step: If you have not talked with the HMO you have chosen once you receive your HMO ID card, call right away. See the HMO Information for toll free Member Services numbers.

PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS