Horizon

Horizon Blue Cross Blue Shield of New Jersey

GROUP ENROLLMENT/CHANGE REQUEST

Attn: Large and Mid-Size Group Enrollment
P.O. Box 10168
Newark, NJ 07101-3168
Fax (973) 274-2297
www.HorizonBlue.com

Group Information – to be completed by Employer.

Group Name: _____ Group Number: _____
Sub Group Number: _____
Date of Hire: ____/____/____ Effective Date/Date of Event: ____/____/____
Reason: _____

A. Type of Activity – to be completed by Employer.

Refer to instructions before completing this form. Print clearly.

☐ **ADD** ☐ **REMOVE** ☐ **OTHER CHANGE**

	Effective Date/Date of Event	Reason for Change
☐ Subscriber	____/____/____	
☐ Spouse	____/____/____	
☐ Civil Union Partner (CUP)	____/____/____	
☐ Domestic Partner (DP)	____/____/____	
☐ Dependent Child	____/____/____	
☐ Over-Age Child as a Dependent Under 31 *(and complete Coverage Continuation section)*	____/____/____	
☐ Name Change	____/____/____	
☐ Change Plan	____/____/____	
☐ Other	____/____/____	
☐ Add/Change Office ID Numbers: Primary Care Provider	____/____/____	

COVERAGE CONTINUATION

☐ **For Employee** Billing: ☒ Group

Date of Loss of Coverage ____/____/____ Qualifying Event #** _____ Date of Qualifying Event ____/____/____

☐ Total Disability* ☐ COBRA/NJSGC Length of Continuation (in months): ☐ 18 ☐ 29
**Attach proof of disability*

☐ **For Spouse/Civil Union Partner*/Domestic Partner** Billing: ☒ Group

Date of Loss of Coverage ____/____/____ Qualifying Event #** _____ Date of Qualifying Event ____/____/____

☐ COBRA/NJSGC Length of Continuation (in months): ☐ 18 ☐ 29 ☐ 36
**Civil union partners are eligible to make an election pursuant to NJSGC, if applicable.*

☐ **For Dependent or Over-aged Child**

☐ COBRA/NJSGC Length of Continuation (in months): ☐ 18 ☐ 29 ☐ 36 Billing: ☒ Group

Date of Loss of Coverage ____/____/____ Qualifying Event #** _____ Date of Qualifying Event ____/____/____

☐ Dependent Under 31 Billing: ☒ Home

Date of Loss of Coverage ____/____/____ Qualifying Event #** _____ Date of Qualifying Event ____/____/____

Home Address: _____

***Qualifying event #s: see list in Instructions.*

B. Employee Information – to be completed by Employee.

☐ **ADD** ☐ **REMOVE** ☐ **CONTINUATION** ☐ **OTHER CHANGE**

If a name change, indicate prior name: _____

Last Name, First Name, M.I. _____

Social Security # _____ Date of Birth ____/____/____ Sex _____

Home Address _____ Apt. _____ City _____ State _____ Zip Code _____

Home Phone _____ E-Mail Address _____

Employer Name _____ Employment Date ____/____/____

Hours Worked
Employer Address _____ City _____ State _____ Zip Code _____

Per Week _____ Work Phone _____ E-Mail Address _____

Primary Care Provider Name _____ Current Patient ☐ Yes ☐ No

NPI # _____ Loc Code _____

Other Health Coverage ☐ Yes ☐ No, If Yes, Payer Name _____

Policy # _____ Medicare ID #, If any _____

C. Race/Ethnicity – to be completed by the Employee, at his/her option.

NOTE: Your response is appreciated but NOT required! *Choose a category that most closely describes you:*

☐ American Indian or Alaskan Native ☐ Black, not of Hispanic origin
☐ Hispanic ☐ Asian or Pacific Islander ☐ White, not of Hispanic origin

D. Plan Option – to be completed by the Employee. Your selection must be offered by your employer.

Medical *Check One:* ☐ S ☐ F ☐ 2 Adults ☐ PC

☐ Horizon Traditional ☐ Horizon PPO (HRA) ☐ Horizon Advantage EPO
☐ Horizon HMO ☐ Horizon PPO (HSA) ☐ Horizon Advantage EPO (HRA)
☐ Horizon POS ☐ Horizon Direct Access (HRA) ☐ Horizon Advantage EPO (HSA)
☐ Horizon PPO ☐ Horizon Direct Access (HSA)
☐ Horizon Direct Access ☐ Horizon EPO

Dental *Check One:* ☐ S ☐ F ☐ 2 Adults ☐ PC

☐ Horizon Dental Option Plan ☐ Horizon Dental PPO Plan ☐ Horizon Dental PPO Access

Vision *Check One:* ☐ S ☐ F ☐ 2 Adults ☐ PC

☐ Horizon Vista I ☐ Horizon Panorama III - ALT. B ☐ Horizon Expanse V
☐ Horizon Vista II ☐ Horizon Panorama IV - ALT. A ☐ Horizon Expanse VI
☐ Horizon Panorama III - ALT. A ☐ Horizon Panorama IV - ALT. B

Prescription *Check One:* ☐ S ☐ F ☐ 2 Adults ☐ PC

S = Single; F = Family; 2 Adults = Husband/Wife, Civil Union Partners or Domestic Partners; P/C = Parent/Child(ren)

The Employee Copy of this application may be used as a temporary ID card for thirty days from the effective date if authorized by Employer. Coverage must be verified with Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc. prior to visiting a physician or admission to a hospital.

E. Other Individuals Covered – to be completed by Employee.

Identify individuals other than yourself for whom you are adding/changing/removing/ continuing coverage. Attach additional pages if necessary, with your signature and dated. Attach proof of disability.

1. SPOUSE/CUP/DP ☐ **ADD** ☐ **REMOVE** ☐ **CONTINUE SPOUSE (COBRA/NJSGC)**
☐ **CONTINUE CU PARTNER (NJSGC)** ☐ **CONTINUE DP (COBRA/NJSGC)** ☐ **OTHER CHANGE**

Last Name, First Name, M.I. _____

Social Security# _____ Date of Birth ____/____/____ Sex _____

Primary Care Provider Name _____ Current Patient ☐ Yes ☐ No

NPI # _____ Loc Code _____

Other Health Coverage ☐ Yes ☐ No, If Yes, Payer Name _____

Policy # _____ Medicare ID #, If any _____

Home or billing address same as Employee? ☐ Yes ☐ No *If No, Complete Section F2*

2. Child ☐ **ADD** ☐ **REMOVE** ☐ **CONTINUATION** ☐ **OTHER CHANGE**

Last Name, First Name, M.I. _____

Social Security# _____ Date of Birth ____/____/____ Sex _____

Primary Care Provider Name _____ Current Patient ☐ Yes ☐ No

NPI # _____ Loc Code _____

Other Health Coverage ☐ Yes ☐ No, If Yes, Payer Name _____

Policy # _____ Medicare ID #, If any _____

If last name is different from Employee's, please explain: _____

Living with Employee? ☐ Yes ☐ No *If No, Complete Section G*

3. Child ☐ **ADD** ☐ **REMOVE** ☐ **CONTINUATION** ☐ **OTHER CHANGE**

Last Name, First Name, M.I. _____

Social Security# _____ Date of Birth ____/____/____ Sex _____

Primary Care Provider Name _____ Current Patient ☐ Yes ☐ No

NPI # _____ Loc Code _____

Other Health Coverage ☐ Yes ☐ No, If Yes, Payer Name _____

Policy # _____ Medicare ID #, If any _____

If last name is different from Employee's, please explain: _____

Living with Employee? ☐ Yes ☐ No *If No, Complete Section G*

F. Additional Spouse/CUP/DP Information – to be completed by Employee.

If not applicable mark as N/A.

1. Employer Name _____ Employer Phone _____

Employer Address _____

City _____ State _____ Zip Code _____

2a. Home Address _____ Apt _____

City _____ State _____ Zip Code _____

2b. Please explain why the address is different: _____

G. Additional Child Information – to be completed by Employee.

Provide information below about children listed in Section E, if they have a different address from the employee. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.

Name _____

Address _____ Apt _____

City _____ State _____ Zip Code _____

Reason: _____

Name _____

Address _____ Apt _____

City _____ State _____ Zip Code _____

Reason: _____

H. Employee Signature

I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I authorize deductions from my earnings for any contributions required from me.

Signature: _____ Date: ___/___/___

I. Over-Age Child's Signature

I represent that all the information supplied in this application regarding the Dependent Under 31 Continuation Election is true and complete.
I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form.
I hereby agree to make premium payments required from me for the Dependent Under 31 Continuation Election.

Signature: _____ Date: ___/___/___

J. Employer Verification

The requested activity is believed eligible and is approved by the Employer.

Employer Representative: _____ Date: ___/___/___

Representative's Title: _____

Reset Form

Horizon
Horizon Blue Cross Blue Shield of New Jersey

ENROLLMENT/CHANGE REQUEST
Horizon BCBSNJ Dental Programs

P.O. Box 1936
Newark, NJ 07101-1936
www.HorizonBlue.com/dental
1-800-4DENTAL

Group Information - To Be Completed by Employer

Group Name	Group Number	Subgroup Number

A. Type of Activity - To Be Completed by Employer *Refer to instructions on back before completing this form. Print clearly.*

1. Enrollment
☐ New Subscriber

Effective Date
__/__/__

Date of Hire
__/__/__

2. Change - *Check all that apply.*

	Date of Event	Reason
☐ Add Spouse		
☐ Domestic Partner		
☐ Civil Union Partner	__/__/__	_____
☐ Add Dependent Child	__/__/__	_____
☐ Name Change	__/__/__	_____
☐ Change Plan	__/__/__	_____
☐ Other	__/__/__	_____
☐ Add/Change Dentist Office ID		

3. Remove or Terminate - *Check all that apply.*

	Effective Date	Reason
☐ Remove Spouse/Domestic Partner/ Civil Union Partner*	__/__/__	_____
☐ Remove Dependent Child*	__/__/__	_____
☐ Employee Withdrawal/Termination	__/__/__	_____

Note: Employee must be enrolled for spouse/domestic partner/civil union partner/ dependent(s) to have coverage.
*Please complete Add/Change/Remove and Name columns in Section D.

4. Continuation of Coverage, i.e., COBRA, State, Total Disability
Not all options are available. Contact Employer for available options.
Coverage For: ☐ Employee ☐ Dependents
Length of Continuation: ☐ 18 mos ☐ 29 mos* ☐ 36 mos ☐ Total Disability
Date of Loss of Coverage: __/__/__
Date of Qualifying Event: __/__/__
*Attach proof of disability

B. Employee Information - Complete Sections B - G

Social Security Number	Last Name, First Name, M.I.		Home Telephone ( )
Home Address	Apt. No.	City, State	ZIP Code
Employer Name			Work Telephone ( )
Work Address		City, State	ZIP Code
Date of Employment		Hours Worked	

C. Plan Option - Your selection must be offered by your employer.

Horizon BCBSNJ	Horizon Healthcare Dental	Contract Type
☐ Horizon Dental Traditional	☐ *Horizon Dental Choice	☐ S - Single ☐ F - Family
☐ Horizon Dental Option	☐ *Horizon TotalCare Dental	☐ 2 Adults
☐ Horizon Dental PPO		☐ P/C - Parent & Child
☐ Horizon Dental PPO Access		

*Please select Dentist Office ID Number-Section D

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. Attach proof if full-time college student. Attach proof of disability.

	(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex M F	Birthdate MM DD YYYY	Social Security Number	Other Dental Coverage Check if Yes	Dentist Office ID Number (if applicable)	NPI Number	Current Patient Check if Yes	Previous Coverage Check if Yes
Employee			☐ ☐	/ /		☐			☐	☐
Spouse			☐ ☐	/ /		☐			☐	☐
Domestic Partner			☐ ☐	/ /		☐			☐	☐
Civil Union Partner			☐ ☐	/ /		☐			☐	☐
Child			☐ ☐	/ /		☐			☐	☐
Child			☐ ☐	/ /		☐			☐	☐
Child			☐ ☐	/ /		☐			☐	☐

E. Other/Previous Insurance

Is your Spouse/Domestic Partner/Civil Union Partner Employed? ☐ Yes ☐ No If "Yes," give name & address of spouse's/ Domestic Partner's/Civil Union Partner's employer.

If "Yes" to Other Dental Coverage (Section D), give name & policy number of insurance carrier, HMO, or other source.

If "Yes" to previous coverage, identify name(s) of persons, give effective date and date coverage terminated, name of previous carrier and plan number and submit a copy of the Certificate of Credible Coverage issued by the previous carrier, if available.

F. Dependent Information

Does any dependent listed in Section D live at a different address than the Employee? ☐ Yes ☐ No If "Yes," who and at what address?

Explain the circumstances.

If any dependent's last name differs from yours, explain the circumstances.

G. Employee Signature

If you have any questions concerning the benefits and services provided by or excluded under this contract, contact a benefits representative at your company before signing this form.

I represent that all the information supplied in this enrollment/change request form is true and complete. I hereby agree to the conditions of enrollment on the reverse side of the employee copy of this enrollment/ change request. I authorize deductions from my earnings for any required contribution.

Employee Signature - *Required*
X

Date __/__/__

E-Mail Address

H. Employer Verification - To Be Completed by Employer

Employer Signature - *Required*
X

Title

Date __/__/__

Employee copy may be used as a temporary ID card for 30 days from the effective date if authorized by employer. Coverage must be verified with Horizon BCBSNJ Dental Programs prior to visiting a specialist or admission to a hospital.

You may complete the required fields below online and then save or print a copy for submission. To save a completed copy to your computer, choose File > Save As to rename the file and save the form with your information to your computer.