Horizon
Horizon Blue Cross Blue Shield of New Jersey

ENROLLMENT/CHANGE REQUEST

Horizon Blue Cross Blue Shield of New Jersey

Attn: Large and Mid-Size Group Enrollment
Horizon Blue Cross Blue Shield of NJ
PO BOX 10168
Newark, NJ 07101-3168

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 __/__/__ _____
☐ Add Dependent Child __/__/__ _____
☐ Name Change __/__/__ _____
☐ Change Plan __/__/__ _____
☐ Other __/__/__ _____
☐ Add/Change Office ID Numbers: Primary Care Physician/Ob/Gyn

3. Remove or Terminate - *Check all that apply.* **Effective Date** **Reason**
☐ Remove Spouse/Domestic Partner* __/__/__ _____
☐ Remove Dependent Child* __/__/__ _____
☐ Employee Withdrawal/Termination __/__/__
NOTE: Employee must be enrolled for spouse/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: ☐ 12 mos ☐ 18 mos ☐ 29 mos ☐ 36 mos ☐ Total Disability*
Date of Loss of Coverage: __/__/__
Date of Qualifying Event: __/__/__
**Attach proof of total disability*

B. Employee Information - Please Complete Sections B - G

Social Security Number	Last Name, First Name, M.I.		Home Telephone ( )
Home Address	Apt.	City, State	ZIP Code
Employer Name			Work Telephone ( )
Work Address		City, State	ZIP Code

Date of employment____/____/____ Hours worked per week _____

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

Medical Check One:	Dental Check One:	Prescription Check One:
☐S ☐F ☐HW (or DP) ☐PC	☐S ☐F ☐HW (or DP) ☐PC	☐S ☐F ☐HW (or DP) ☐PC

☐ Horizon Traditional
☐ Horizon HMO
☐ Horizon POS
☐ Horizon PPO
☐ Horizon Direct Access
☐ Horizon PPO (HRA)
☐ Horizon PPO (FSA)
☐ Horizon PPO (HSA)
☐ Horizon Direct Access (HRA)
☐ Horizon Direct Access (FSA)
☐ Horizon Direct Access (HSA)
☐ Horizon EPO
☐ Other _____

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.

	(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex M F	Birthdate MM DD YYYY	Social Security Number	Other Health Coverage	Other Rx Drug Coverage	Primary Care Office ID Number	Current Patient	Previous Coverage
Employee			☐ ☐	/ /		Yes ☐	Yes ☐		Yes ☐	Yes ☐
Spouse			☐ ☐	/ /		☐	☐		☐	☐
Domestic Partner			☐ ☐	/ /		☐	☐		☐	☐
Child			☐ ☐	/ /		☐	☐		☐	☐
Child			☐ ☐	/ /		☐	☐		☐	☐
Child			☐ ☐	/ /		☐	☐		☐	☐

E. Other/Previous Insurance

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

If "Yes" to Other Health Coverage (Section D), give name & policy number of insurance carrier, HMO, or other source. If enrolled in Medicare Parts A and/or B, identify the coverage and provide the Medicare ID#.

If "Yes" to Other Rx Drug 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 ID number.

F. Dependent Information

Does any dependent listed in Section D live at a different address than the Applicant? ☐ Yes ☐ No If "Yes," who and 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 application is true and complete. I hereby agree to the conditions on the reverse side of this enrollment/change request. I authorize deductions from my earnings for any required contributions.

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 or Horizon Healthcare of New Jersey, Inc. prior to visiting a physician or admission to a hospital.

ENROLLMENT COPY

Instructions

Employer

- Complete the **Employer Group Information** in the upper right corner of the form.
- **Section A - Type of Activity:** Check box(es) indicating reason(s) for submitting Enrollment/Change Request Form. If reason is other than indicated, check "Other" and provide reason (i.e., rehire, open enrollment or newly eligible).
- Complete **Section H - Employer Verification** in the lower right corner of the form.
  - Employer must complete this section for all new enrollments, coverage changes and terminations.
  - Employer must sign and date the Enrollment/Change Request Form in order for it to be processed.

Employee - Complete Sections B - G

Section B - Employee Information:

Complete all information in order for your application to be processed.

Section C - Plan Option:

- Check one Plan Option box and indicate Plan Option Name (where applicable).
- Select only an option offered by your employer.
- S-Single, F-Family, H/W-Husband & Wife (or Domestic Partners), P/C-Parent & Child(ren)

Section D - Individuals Covered:

- Add/Change/Remove - Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
- If a dependent is a full-time post-secondary student, you **must** attach a current course schedule or a letter from the school confirming full-time student status. If a dependent is disabled and being continued beyond the limiting age, attach proof of disability.
- If you or your dependent(s) have other Health or Rx drug coverage, check off the "Yes" box(es) and complete Section E - Other/Previous Insurance.
- From the appropriate provider directory, locate the alphanumeric office ID number for the primary care physician. Indicate office ID number selection(s) on the form.
- If you are a current patient, please check "Current Patient" box.
- If you had Previous Coverage, please check "Previous Coverage" box.

Section E - Other/Previous Insurance:

Complete this section for all new enrollments or coverage changes. Coverages includes group coverage, governmental coverage, a church plan or Medicare.

Section F - Dependent Information:

Complete this section for all new enrollments or coverage changes.

Section G - Employee Signature:

- Complete this section for all new enrollments, coverage changes and terminations.
- Employee must sign and date the Enrollment/Change Request form in order for it to be processed.

Section H - Employer Verification:

- Employer must complete this section for all new enrollments, coverage changes and terminations.
- Employer must sign and date the Enrollment/Change Request Form in order for it to be processed.

Conditions of Enrollment

Employee Acknowledgements and Agreements

On behalf of myself and the dependents listed on the reverse side, I agree to or with the following:

1. a) I authorize the sources stated below to give to Horizon BCBSNJ or Horizon Healthcare of New Jersey, Inc., or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition. Authorized sources are: any physician or medical professional; any hospital, clinic or other medical care institution; any carrier; any consumer reporting agency; any employer.

   b) I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which Horizon BCBSNJ or Horizon Healthcare of New Jersey, Inc. has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.

   c) I know that I have a right to receive a copy of this authorization if I request one.

   d) I agree that a photocopy of this authorization is as valid as the original.

2. I acknowledge by enrolling in a Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) or Horizon Healthcare of New Jersey, Inc. plan, coverage is provided by Horizon BCBSNJ or Horizon Healthcare of New Jersey, Inc. in accordance with the contract.
3. Enrollment of myself and of the listed dependents into the plan is effective on acceptance by Horizon BCBSNJ or Horizon Healthcare of New Jersey, Inc.
4. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. My employer is hereby authorized to withhold payments from my wages, as appropriate.

Misrepresentation

5. Any person who includes any false or misleading information on an Enrollment/Change Request Form for a health benefits plan is subject to criminal and civil penalties.