Horizon

Horizon Blue Cross Blue Shield of New Jersey

*Making Healthcare Work.*

# SMALL GROUP ENROLLMENT/ CHANGE REQUEST

RESET

Mail to: Horizon BCBSNJ
Attn: Small Group Enrollment
P.O. Box 607 Department A
Newark, NJ 07101-0607
Email to: small_group_maintenance_enrollment_team@HorizonBlue.com
Fax (973) 274-2227
HorizonBlue.com

**Group Information – to be completed by Employer.**

Group Name: _____ Group Number: _____

Sub Group Number: _____ ☐ Enrollment of a new Subscriber

Date of Hire: _____/_____/_____ Effective Date/Date of Event: _____/_____/_____

Reason for Change: _____

**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 |
|---|---|---|
| ☐ Spouse | _____/_____/_____ | _____ |
| ☐ Civil Union Partner (CUP) | _____/_____/_____ | _____ |
| ☐ Domestic Partner (DP) | _____/_____/_____ | _____ |
| ☐ Dependent Child | _____/_____/_____ | _____ |
| ☐ Over-Age Child as a Dependent Under 31 *(please complete Coverage Continuation section)* | _____/_____/_____ | _____ |
| ☐ Name Change | _____/_____/_____ | _____ |
| ☐ Change Plan | _____/_____/_____ | _____ |
| ☐ Other | _____/_____/_____ | _____ |

**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 Even _____/_____/_____

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 _____/_____/_____

Employer Address _____ City _____ State _____ Zip Code _____

Hours Worked 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 _____

Dentist Office ID number (if applicable) _____ Current Patient ☐ Yes ☐ No

*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.*

## 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. Please refer to the Instructions for available continuation rights.

**Medical Plan Option** ***Check One:***

☐ Horizon Advantage Direct Access ☐ PCMH Advantage EPO
☐ Horizon Advantage Direct Access (HSA) ☐ OMNIA
☐ Horizon Advantage EPO (HSA) ☐ OMNIA (HSA)
☐ Horizon Advantage EPO ☐ Other _____

Select one coverage option: ☐ S ☐ F ☐ H/W ☐ CUP ☐ DP ☐ P/C

**Pediatric Dental and Family Pediatric Dental** ***Check One:***

☐ Horizon Young Grins (only provides benefits for members under 19)
☐ Horizon Family Grins
☐ Horizon Family Grins Plus

Select one coverage option: ☐ S ☐ F ☐ H/W ☐ CUP ☐ DP ☐ P/C

**Family Dental** ***Check One:***

☐ Horizon Dental Option Plan ☐ Horizon Dental Choice
☐ Horizon Dental PPO ☐ Horizon Healthy Smiles
☐ Horizon Dental PPO Access ☐ Horizon Healthy Smiles Plus
☐ Horizon Dental Companion

Select one coverage option: ☐ S ☐ F ☐ H/W ☐ CUP ☐ DP ☐ P/C

**Vision Plan Option** ***Check One:***

☐ Horizon Expanse V ☐ Horizon Panorama IV (Alt A) ☐ Horizon Vista II
☐ Horizon Expanse VII (Alt A) ☐ Horizon Panorama IV (Alt B) ☐ Horizon Vista III
☐ Horizon Expanse VII (Alt B) ☐ Horizon Vista IV
☐ Horizon Expanse VIII

Select one coverage option: ☐ S ☐ F ☐ H/W ☐ CUP ☐ DP ☐ P/C

S = Single F = Family H/W = Husband/Wife CUP = Civil Union Partners DP = Domestic Partners P/C = Parent/Child(ren)

## 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.*

**SPOUSE/CUP/DP** ☐ **ADD** ☐ **REMOVE** ☐ **CONTINUE SPOUSE (COBRA/NJSGC)**
☐ **CONTINUE CU PARTNER (NJSGC)** ☐ **CONTINUE DP (NJSGC)**

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 _____

Dentist Office ID number (if applicable) _____ Current Patient ☐ Yes ☐ No

Employed? ☐ Yes ☐ No *If yes, Complete Section F*

**1. 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 _____

Dentist Office ID number (if applicable) _____ Current Patient ☐ Yes ☐ No

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

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

**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 _____

Dentist Office ID number (if applicable) _____ Current Patient ☐ Yes ☐ No

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 _____

**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: _____

_____

**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 _____

Dentist Office ID number (if applicable) _____ Current Patient ☐ Yes ☐ No

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 _____

**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: _____

**Instructions**

**Employers**

You must complete the Group Information and sections A and J in order for this application to be processed.

**Employees**

You must complete sections B through H and submit the signature of each Over-Age Child for which a Dependent Under 31 Continuation Election is made in accordance with Section I in order for this application to be processed.

- Please PRINT except when a signature is requested.
- If a dependent is disabled and you want to continue his or her Medical and/or Family Dental coverage beyond age 26, you do not have to make a COBRA or NJSGC or Dependent Under 31 election. Instead select "Other" in Section A and attach proof of total disability.
- For Pediatric Dental and Family Pediatric Dental plans, Total Disability and COBRA are available continuation options; NJSGC and Dependent Under 31 continuation are not available. For Vision plans, Total Disability and COBRA are available continuation options; NJSGC and Dependent Under 31 continuation are not available.
- For Horizon Dental Option, Horizon Dental PPO, Horizon Dental PPO Access and Horizon Dental Choice, if a dependent is a full-time college student, you must attach a current course schedule or a letter from the school confirming full-time student status (12 or more credits).
- You can obtain the providers' correct names from the appropriate provider directory. You may also obtain each provider's NPI and LOC Code number from the provider directory or at: **www.HorizonBlue.com.** Providers with multiple office locations and individual providers who belong to more than one practice or provider entity may have more than one NPI number. You should confirm the correct NPI number for the specific provider and office location where you will be seen by contacting that office directly.
- If the Plan Option selected is Horizon Dental Choice-from the appropriate Provider directory, locate the alphanumeric office ID code for the dentist. Indicate office ID number selection(s) and NPI Number on the form.
- If you are a current patient, please check the "Current Patient" box. (only applicable if the Plan Option selected is Horizon Dental Choice).
- If the Horizon Young Grins plan is selected, only enrollees under age 19 can receive benefits.
- If Vision Plan Option is selected, all enrollees must be age 19 or over to qualify for benefits.

**Qualifying Events**

COBRA and NJSGC

C1. Termination of job or reduction in hours
C2. Employee enrollment in Medicare (COBRA only)
C3. Divorce (COBRA/NJSGC); civil union dissolution (NJSGC) or termination of domestic partnership (NJSGC)
C4. Death of employee
C5. Loss of dependent child status (aged out) under the plan.
C6. Disability (occurring subsequent to another qualifying event)

Dependent Under 31

D1. Loss of dependent status (aged out) and otherwise eligible
D2. Re-establish eligibility: residency
D3. Re-establish eligibility: nonresident full-time student
D4. Re-establish eligibility: change in marital status
D5. Re-establish eligibility: change in parental status
D6. Re-establish eligibility: termination of other coverage

**Conditions of Enrollment - Applicant Acknowledgements and Agreements**

On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer reporting agency, and any employer to give Horizon BCBSNJ[1], or any consumer reporting agency acting on behalf of Horizon BCBSNJ, information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that Horizon BCBSNJ has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one.
4. I agree Horizon BCBSNJ will provide coverage in accordance with the terms of the contract for the group plan/policy.
5. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the group plan/policy if premiums are not paid timely. I authorize my Employer to withhold payments from my wages as contribution to the premium, as appropriate.

**Misrepresentations**

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.

**Notices**

**General Notice of Special Enrollment Rights**

If you are declining enrollment under your group health plan for yourself and/or your dependents (if your plan includes coverage for dependents) because of other health insurance or other group health plan coverage, you may be able to enroll yourself and those dependents in this group health plan if you or the dependents lose eligibility for that other coverage (or if the other employer stops contributing toward your or your dependents' other coverage). However, if the other coverage was continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you must request enrollment within 30 days after the COBRA coverage ends. If the other coverage was not COBRA continuation coverage, you must request enrollment within 90 days after your or your dependents' other coverage ends (or after the other employer stops contributing toward the other coverage).

In addition, if this plan includes coverage for dependents and you acquire a new dependent as a result of marriage, birth, adoption, placement for adoption, or placement in foster care you may be able to enroll yourself and your dependents under this plan after declining its coverage. However, you must request enrollment within 31 days after the child's birth or within 30 days after the marriage, adoption, placement for adoption, or placement in foster care.

If you decline group health coverage under this plan, you will be asked to state in writing whether the declination was due to the existence of other health coverage.

To request special enrollment or obtain more information about it, contact your benefits manager, if available, or your employer.

**Notice on Dependent Under 31 Continuation**

Horizon Blue Cross Blue Shield of New Jersey will bill over- age dependents directly and enrollees will remit the premium directly to Horizon BCBSNJ. When Dependent Under 31 Continuation is selected, the home address must be completed under Section "A - Type of Activity" even when it is the same as the employee's address.

***Important Note:***

- Although the employee must continue eligibility under the dependent's plan for continued coverage of the dependent, in addition to the additional applicable eligibility criteria, coverage for the dependent will be issued as stand-alone coverage. All cost-sharing requirements and limitations will apply and will not be combined with the employee's policy. Consequently, covered expenses incurred by the over-age dependent will not contribute to family deductibles and out-of-pocket maximums, nor will family incurred expenses contribute to the over-age dependent's deductibles or out-of-pocket maximums.

Group Subscriber on behalf of itself and its participants hereby expressly acknowledges its understanding this agreement constitutes a contract solely between Subscriber and Horizon BCBSNJ, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Horizon BCBSNJ to use the Blue Cross and Blue Shield Service Marks in the State of New Jersey, and that Horizon BCBSNJ is not contracting as the agent of the Association. Group Subscriber on behalf of itself and its participants further acknowledges and agrees that it has not entered into this agreement based upon representations by any person other than Horizon BCBSNJ and that no person, entity, or organization other than Horizon BCBSNJ shall be held accountable or liable to Group Subscriber for any of Horizon BCBSNJ's obligations to Group Subscriber created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of Horizon BCBSNJ other than those obligations created under other provisions of this agreement.



[1] Horizon BCBSNJ refers to Horizon Healthcare Services, Inc., doing business as Horizon Blue Cross Blue Shield Of New Jersey or any of its wholly owned subsidiaries including Horizon Insurance Company, Horizon Healthcare Dental, Inc., and Horizon Healthcare of New Jersey, Inc., doing business as Horizon NJ Health.