



ENROLLMENT/CHANGE REQUEST

Horizon Blue Cross Blue Shield of New Jersey

Attn: Small Group Enrollment
Horizon Blue Cross Blue Shield of NJ
PO Box 607, Dept. A
Newark, NJ 07101-0607
www.horizonblue.com

Horizon Blue Cross Blue Shield of New Jersey

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 <input type="checkbox"/> New Subscriber Effective Date ____/____/____ Date of Hire ____/____/____	2. Change - Check all that apply. <table border="1"> <tr> <td><input type="checkbox"/> Add Spouse/Domestic Partner</td> <td>____/____/____</td> <td>Reason</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Add Dependent Child</td> <td>____/____/____</td> <td>Reason</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Name Change</td> <td>____/____/____</td> <td>Reason</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Change Plan</td> <td>____/____/____</td> <td>Reason</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Other</td> <td>____/____/____</td> <td>Reason</td> <td>_____</td> </tr> <tr> <td colspan="4"><input type="checkbox"/> Add/Change Office ID Numbers: Primary Care Physician/Ob/Gyn</td> </tr> </table>	<input type="checkbox"/> Add Spouse/Domestic Partner	____/____/____	Reason	_____	<input type="checkbox"/> Add Dependent Child	____/____/____	Reason	_____	<input type="checkbox"/> Name Change	____/____/____	Reason	_____	<input type="checkbox"/> Change Plan	____/____/____	Reason	_____	<input type="checkbox"/> Other	____/____/____	Reason	_____	<input type="checkbox"/> Add/Change Office ID Numbers: Primary Care Physician/Ob/Gyn				3. Remove or Terminate - Check all that apply. <table border="1"> <tr> <td><input type="checkbox"/> Remove Spouse/Domestic Partner*</td> <td>____/____/____</td> <td>Effective Date</td> <td>____/____/____</td> <td>Reason</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Remove Dependent Child*</td> <td>____/____/____</td> <td>Effective Date</td> <td>____/____/____</td> <td>Reason</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Employee Withdrawal/Termination</td> <td>____/____/____</td> <td>Effective Date</td> <td>____/____/____</td> <td>Reason</td> <td>_____</td> </tr> </table> <p>NOTE: Employee must be enrolled for spouse/dependent(s) to have coverage. *Please complete Add/Change/Remove and Name columns in Section D.</p>	<input type="checkbox"/> Remove Spouse/Domestic Partner*	____/____/____	Effective Date	____/____/____	Reason	_____	<input type="checkbox"/> Remove Dependent Child*	____/____/____	Effective Date	____/____/____	Reason	_____	<input type="checkbox"/> Employee Withdrawal/Termination	____/____/____	Effective Date	____/____/____	Reason	_____	4. Continuation of Coverage, i.e., COBRA, State, total disability <small>Not all options are available. Contact Employer for available options.</small> Coverage For: <input type="checkbox"/> Employee <input type="checkbox"/> Dependents Length of Continuation: <input type="checkbox"/> 12 mos <input type="checkbox"/> 18 mos <input type="checkbox"/> 29 mos <input type="checkbox"/> 36 mos <input type="checkbox"/> Total Disability* Date of Loss of Coverage: ____/____/____ Date of Qualifying Event: ____/____/____ <small>*Attach proof of total disability</small>
<input type="checkbox"/> Add Spouse/Domestic Partner	____/____/____	Reason	_____																																										
<input type="checkbox"/> Add Dependent Child	____/____/____	Reason	_____																																										
<input type="checkbox"/> Name Change	____/____/____	Reason	_____																																										
<input type="checkbox"/> Change Plan	____/____/____	Reason	_____																																										
<input type="checkbox"/> Other	____/____/____	Reason	_____																																										
<input type="checkbox"/> Add/Change Office ID Numbers: Primary Care Physician/Ob/Gyn																																													
<input type="checkbox"/> Remove Spouse/Domestic Partner*	____/____/____	Effective Date	____/____/____	Reason	_____																																								
<input type="checkbox"/> Remove Dependent Child*	____/____/____	Effective Date	____/____/____	Reason	_____																																								
<input type="checkbox"/> Employee Withdrawal/Termination	____/____/____	Effective Date	____/____/____	Reason	_____																																								

B. Employee Information - Complete Sections B - H

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: S F H/W (or DP) P/C
Dental Check One: S F H/W (or DP) P/C
Prescription Check One: S F H/W (or DP) P/C

 Horizon Traditional Horizon HMO
 Horizon POS Horizon PPO
 Horizon Direct Access Prescription
 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	Primary Care Office ID Number	Current Patient	Previous Coverage
Employee			<input type="checkbox"/> <input type="checkbox"/>	/ /		Yes <input type="checkbox"/>		Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Spouse			<input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Domestic Partner			<input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Child			<input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Child			<input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Child			<input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

E. Pre-Existing Conditions Statement

NOTE: This information may ONLY be used to determine if a condition is a pre-existing condition. You CANNOT be denied coverage under a health benefits plan on the basis of accurate responses to the following questions. Carriers can only use the information to expedite the processing of claims.

Yes No

1. During the past 6 months have you or any dependent to be covered had or been diagnosed as having any of the following? If "Yes," check appropriate box(es) below.

<input type="checkbox"/> a. Alcoholism or Drug Abuse	<input type="checkbox"/> h. Heart Disorder or Condition
<input type="checkbox"/> b. Arthritis	<input type="checkbox"/> i. High Blood Pressure
<input type="checkbox"/> c. Blood Disorder	<input type="checkbox"/> j. Kidney or Liver Disorder
<input type="checkbox"/> d. Back or Neck Disorder, Injury or Pain	<input type="checkbox"/> k. Lung or Respiratory Disorder
<input type="checkbox"/> e. Cancer or Tumors	<input type="checkbox"/> l. Mental or Nervous Disorder
<input type="checkbox"/> f. Diabetes	<input type="checkbox"/> m. Paralysis, Stroke or Epilepsy
<input type="checkbox"/> g. Gastro or Intestinal Disorder	

Yes No

2. During the past 6 months, have you or any dependent to be covered:

a. been examined or treated by a physician or other health care provider for any condition, illness or injury, other than as stated above?

b. been advised to have treatment or surgery or testing that has not been done?

c. been admitted to a hospital or other health care facility as an inpatient?

d. taken prescribed medications?

Please give details for "Yes" answers to any part of Questions 1 or 2 on a separate sheet of paper. This separate sheet should be signed and dated.

F. Other/Previous Insurance

Is your spouse or domestic partner employed? Yes No If "Yes," give name & address of spouse's or domestic partner's employer.

If "Yes" to Other Health Coverage (Section D.) give name and 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 number.

If "Yes" to Previous Coverage, identify name(s) of persons, give effective date and date coverage terminated, name of previous carrier and plan number.

G. Dependent Information

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

Explain the circumstances.

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

H. Employee Signature

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

I represent that all information supplied in this application 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 contributions.

Employee Signature - Required

X

Date ____/____/____ E-Mail Address _____

I. Employer Verification - To Be Completed by Employer

Employer Signature - Required

X

Title _____ Date ____/____/____

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 I - 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 - H

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 the 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 coverage, check off the “Yes” box and complete section F - 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 the “Current Patient” box.

Section E - Pre-Existing Conditions Statement:

This section must be completed by persons enrolling in group coverage in a group of 2-5 employees and by late entrants.

Section F - Other/Previous Insurance:

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

Section G - Dependent Information:

Complete this section for all new enrollments or coverage changes.

Section H - 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 I - 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 Blue Cross Blue Shield of New Jersey 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 Blue Cross Blue Shield of New Jersey 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 or Horizon Healthcare of New Jersey, Inc. plan, coverage is provided by Horizon Blue Cross Blue Shield of New Jersey 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 Blue Cross Blue Shield of New Jersey 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.