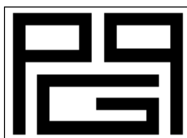

PROFESSIONAL GROUP PLANS, INC.

Specializing in Employee Benefits

Horizon BC/BS of New Jersey New Business Submission Checklist

___ **Employer Application**

___ **Small Employer Certification**

___ **Copy of Complete Proposal**

___ **Employee Enrollment Form(s)**

___ **Prior Carrier Bill**

___ **Spouse's Business Statement**
(required for a group of 3 with 2 eligibles who are married & each are taking single coverage)

___ **Employee Waiver Form(s)**

___ **Late Paper Form (if applicable)**

___ **State Quarterly Wage & Tax Statement**

___ **First Month's Premium Check Payable to:**
Horizon BC/BS of NJ

___ **Forms Must Be Submitted to PGP Office**
Prior to the effective date.

If you have any questions, please contact your PGP representative.

Updated 07/28/03

225 Wireless Blvd., 2nd Fl. • Hauppauge, New York 11788 • Tel: 631.951.9200 • Fax: 631.951.9623 • www.pgpbenefits.com

Horizon Blue Cross Blue Shield of New Jersey

Small Employer Group Application Instructions

Instructions

The attached forms should be completed with the assistance of your authorized Broker or Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) Sales Representative. **Please complete all necessary forms in their entirety. Please print in ink or type your responses.**

Ensure that all areas requiring a **signature and date are complete.** The Officer, Partner, Owner and / or Correspondent signing the application must be listed on the New Jersey Small Employer Certification.

Completed enrollment application forms should be sent to your authorized Broker or Horizon BCBSNJ Sales Representative **prior to your effective date.**

Documents Included

Attached you will find the forms that must be completed and submitted for each New Jersey small employer group applying for standard health insurance coverage:

- Application for a Small Employer Health Benefits Policy
- New Jersey Small Employer Certification
- Small Employer Health Benefits Waiver of Coverage – One form is needed for each employee waiving or refusing coverage. This form may be photocopied as needed.

Other Required Documents

In addition to the forms listed above, **depending on group size / composition and preferred payment method, the following items may also be required:**

- Payroll verification through appropriate tax documentation, i.e., WR30 (required for groups of two to five eligibles)
- Spousal Business Statement (required for husband and wife-only groups) (#3268)
- Automatic Pay Plan Application (#8977)

When submitting your paperwork as required above, **you must also submit the following:**

- Enrollment Change/Request Form (#6803) – One form is needed for each employee enrolling. Your authorized Broker or Horizon BCBSNJ Sales Representative will provide these forms.
- First month's premium – All new cases must be submitted with a company check for the first month's premium payable to Horizon BCBSNJ. If a case is submitted without a premium check, the case will be returned.
- Prior/Current Carrier's most recent billing statement – Required if replacing group medical coverage.
- Rate Quote – The rate quote generated for the group should match the product(s) selected in Section II of the Application for a Small Employer Health Benefits Policy.

Rate Quotes

The rate quote is an estimate based on information provided by your authorized Broker or Horizon BCBSNJ Sales Representative. If there is inaccurate or missing information on the original quote, the rate may change based on an official review of the paperwork submitted to Horizon BCBSNJ.

Mailing Instructions

Please send the completed paperwork and attachments to:

Horizon Blue Cross Blue Shield of New Jersey
Three Penn Plaza East PP-09W
Newark, NJ 07105-2200

Horizon HMO is issued by Horizon Healthcare of New Jersey, a subsidiary of Horizon Blue Cross Blue Shield of New Jersey. Horizon Blue Cross Blue Shield of New Jersey is an independent licensee of the Blue Cross Blue Shield Association.

Horizon Blue Cross Blue Shield of New Jersey

APPLICATION FOR A SMALL GROUP HEALTH BENEFITS POLICY

Please print or type Policy number ______________ ☐ New Policy ☐ Change in Policy Requested Effective Date ______________

Note: The Effective Date will be on or after the date Horizon Blue Cross Blue Shield of New Jersey approves the application.

SECTION I: POLICYHOLDER INFORMATION

1. Policyholder (full legal name of company): ______________

2. Tax Identification Number: ______________

3. Main Address: ______________
   Street City State Zip

   Mailing Address: ______________
   Street City State Zip

   Telephone: ______________ Facsimile: ______________ Email Address: ______________

4. Name of Correspondent: ______________ Title: ______________

5. Type of Organization: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Other (explain): ______________

6. Nature of Business (specify): ______________ SIC Code: ______________

7. Number of eligible employees in your company: ______________
   Refer to the New Jersey Small Employer Certification for the definition of an eligible employee.

8. Number of eligible employees to be insured: ______________ 9. Class or classes to be excluded: ______________

10. Insurance Requested For: ☐ Employees Only ☐ Employees and Dependents
    Should the plan provide coverage for domestic partners as permitted by P.L. 2003, c. 246? ☐ Yes ☐ No
    If yes, should the plan provide coverage for coverage of children of a covered domestic partner? ☐ Yes ☐ No

11. Is the employer subject to the requirements of COBRA? ☐ Yes ☐ No

12. Is the employer subject to the requirements of Medicare as Secondary Payor Rules for eligibility due to age? ☐ Yes ☐ No
    Due to disability? ☐ Yes ☐ No

13. Waiting period before employees become insured: (may not exceed 6 months) Present employees : __________ New or Rehired Employees: __________

14. What percentage of the premium will the employer pay? ______________ 15. Deposit $ ______________

Premium Paid: ☐ Monthly ☐ Quarterly ☐ Automatic checking withdrawal
Premium will be due as of the effective date. The premium for the first month of coverage must be attached.

Affiliates, subsidiaries or branches (Must be included for purposes of participation)

Legal Name & Location	No. of eligible employees in this company	No. of eligible employees to be insured

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SECTION II: SPECIFICATIONS FOR COVERAGE

Health Benefits (Select One): **Co-payment Options (Select One):** ☐ **$5** ☐ **$10** ☐ **$15** ☐ **$20** ☐ **$30**

1. ☐ **Horizon HMO**

Plan Description ____

____

Maximum Out Of Pocket: Network ____________

2. ☐ **Horizon HMO Coinsurance Plus**

Plan Description ____

____

Maximum Out Of Pocket: Network ____________

3. **Horizon PDS**

Plan Description ____

____

Maximum Out Of Pocket: Network ____________ Non-Network ____________

4. ☐ **Horizon Direct Access**

Plan Description ____

____

Maximum Out Of Pocket: Network ____________ Non-Network ____________

5. ☐ **Horizon PPO**

Plan Description ____

____

Maximum Out Of Pocket: Network ____________ Non-Network ____________

6. ☐ **Horizon Comprehensive Plan A - E**

Plan Description ____

____

Maximum Out Of Pocket: ____________

7. ☐ **Prescription Drug (Select One):**

☐ Retail: $5 / $10 Mail Order: $0 / $5 No Deductible

☐ Retail: $15 Mail Order: $22.50

☐ Retail: 50% Coinsurance Mail Order: Not Available

Deductible Options (Select One): ☐ **$ 0** ☐ **$ 50** ☐ **$100**

☐ Retail: $15 Mail Order: $0

☐ Retail: $5 / $10 / $20 Mail Order: $7.50 / $15 / $30

☐ Retail: $10 / $20 / $35 Mail Order: $30 / $60 / $105

☐ Retail: $12 / $25 / $40 Mail Order: $24 / $50 / $80 No Deductible This option available for Horizon HMO only

Note: Prescription Drug is not available with High Deductible Plan Options or Horizon Basic Plan A.

8. ☐ **One-Bill Option** Select this option when purchasing multiple health products and one summary billing statement is requested.

Note: Replacement ID cards will be issued for existing subgroups.

SECTION III: ALL QUESTIONS MUST BE ANSWERED

1. Is there any Group Health Plan:
   - now in force and to be continued? ☐ Yes ☐ No
   - currently being applied for? ☐ Yes ☐ No

   If "Yes" identify the name of the Group Health Plan, give a description of the plan(s) and name of insurance carrier(s)__________

2. Name of present or prior group carrier __________

   Effective date of prior coverage __________ Cancellation/termination date __________

   Is the coverage applied for in this application replacing other group insurance? ☐ Yes ☐ No

   If "Yes", give reason __________

   Plan being replaced : ☐ A ☐ B ☐ C ☐ D ☐ E ☐ HMO ☐ HMO-POS ☐ Dual Contract POS ☐ Other __________

3. Has your firm been uninsured for 3 or more months prior to application? ☐ Yes ☐ No

4. What forms of insurance are now or were in force? ☐ Health Benefits
   ☐ Prescription Drugs (attach copies of Booklet/Certificate and most recent Billing Statement)

5. Are extended benefits provided in case of termination of health benefits? ☐ Yes ☐ No

6. To the best of your knowledge are there any current or former employees or their eligible dependents whose health insurance is being continued? ☐ Yes ☐ No

Please provide the following information for each current/former employee or dependent on health continuations.

Name of Employee/Dependent	Date of Birth	Type of Continuation State/Federal/ Extended Benefits	Reason for Termination Disability/Other	Continuation Dates Start End

If additional space is needed, attach a separate sheet, signed and dated.

7. To the best of your knowledge:
   a. Are any employees or dependents presently incapacitated? ☐ Yes ☐ No
   b. Are any dependent children incapable of self-support due to a physical or mental disability? ☐ Yes ☐ No

Additional space to explain if items 1, 2 or 3 were answered "Yes". Refer to the question number, and give details including names, where appropriate.

____

____

____

____

8. Does the employer participate in an arrangement with a Professional Employer Organization? ☐ Yes ☐ No
   (Refer to Advisory Bulletin 00-SEH-02 if you need information concerning what constitutes a Professional Employer Organization.)

SECTION IV: SIGNATURE

It is understood that, except as provided under applicable regulations, no individual shall become insured while not actively at work on a full-time basis, and only full-time employees are eligible. A full-time employee is one who regularly works at least 25 hours per week at his employer's place of business. It is further understood that no agent has the power on behalf of Horizon Blue Cross Blue Shield of New Jersey to make or modify any request or application for insurance or to bind Horizon Blue Cross Blue Shield of New Jersey by making any promises or representation or by giving or receiving any information.

It is further understood that no insurance will be effective unless and until the application is accepted in writing by Horizon Blue Cross Blue Shield of New Jersey. No contract of insurance is to be implied in any way on the basis of the completion and or submission of this application.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

__________ __________

Print name of Officer, Partner, or Proprietor Signature of Officer, Partner, or Proprietor

__________ Dated at __________ on __________

Witness to Signature

Note: If there are any modifications to the statements and answers given in this application (i.e., crossed out, whited-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.

AGENT PRODUCER INFORMATION (THIS INFORMATION MUST BE ANSWERED COMPLETELY)

BROKER SIGNATURE | DATE | VENDOR NUMBER

BROKER-NAME | NAME OF AGENCY | TELEPHONE NUMBER

STREET | CITY | STATE | ZIP CODE

OTHERS (NAME, TITLE)

SPECIAL INSTRUCTIONS

FOR INTERNAL UNDERWRITING USE

☐ Approved for ______ Number of Subscribers ______

☐ Declined

Band ______ Date ______

Underwritten By ______ Pre-Ex Applies ☐ Yes ☐ No

FOR INTERNAL GROUP ENROLLMENT USE

	HMO	POS	DA	PPO	MSA	A	B	C	D	E	Rx	Dental
Coverage Code c/o												
TOTAL APPLICATIONS SUBMITTED												
TRANSFER FROM GROUP # ______												
REFUSALS/WAIVERS LISTING ATTACHED (IF APPLICABLE)												
EMPLOYER CONTRIBUTION												
EFFECTIVE DATE												
FUTURE RATE RENEWAL DATE												
SALES CREDITS												

SALES CONSULTANT SIGNATURE | DATE | ITEM NUMBER

APPROVED BY: SALES ADMINISTRATION SIGNATURE | TITLE | DATE

CONTRACT DEVELOPMENT SIGNATURE | TITLE | DATE

Horizon Blue Cross Blue Shield of New Jersey

NEW JERSEY SMALL EMPLOYER CERTIFICATION

Legal Name and Address of Company: ______________________________
Name

____
Street City State Zip

Group Policy Number or Group Number: ______________________________
(if a current customer)

Group Health Benefits Policy Participation

Please indicate below the number of employees by work location/State. All employees must be included, regardless of whether or not they currently have medical coverage and through whom that coverage is provided.

	Number of Employees				
Work Location (list by State)	Full-time	Part-time	Retired	COBRA or State Continuees	Other

For Existing Small Employer Groups in the State of New Jersey OR New Applicants

An Eligible Employee is one who works on a full-time basis with a normal work week of 25 or more hours for compensation. An employee who works less than 25 hours per week, on a temporary or substitute basis, or an employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement is not an eligible employee.

Total Number Eligible Employees ________

Total Number Eligible Employees applying / enrolling for health benefits coverage ________

Total Number Eligible Employees waiving health benefits coverage under the policy with coverage under their spouse's coverage, other than individual coverage, or any Health Benefits Plan offered by the employer ________

Total Number Eligible Employees waiving health benefits coverage under the policy without coverage under a spouse's coverage, other than individual coverage; or any Health Benefits Plan offered by the employer ________

Total Number Eligible Employees in an ineligible class or classes ________

Is your firm subject to Working Aged Provisions of federal law (TEFRA/DEFRA)? ☐ Yes ☐ No
(You *may* be subject to the law if you employed 20 or more employees for 20 weeks in the current or prior calendar year)

Is your firm subject to the requirements of the federal COBRA law? ☐ Yes ☐ No
(You *may* be subject to the law if you employed 20 or more employees during 50% or more of the working days during the previous calendar year).

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CERTIFICATION AS A SMALL EMPLOYER IN THE STATE OF NEW JERSEY IN ACCORDANCE WITH NEW JERSEY STATUTE, CHAPTER 27A OF TITLE 17B

For a policy of Group Health Benefits Insurance

(Please sign and date appropriate section indicating whether or not you meet the definition of a small employer)

"Small Employer" means, in connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that:

- employed average of at least two, but not more than 50, eligible Employees on business days during the preceding Calendar Year and
- employs at least two Employees on the first day of the Plan Year, and
- the majority of the Employees are employed in New Jersey.

All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an employer that was not in existence during the preceding Calendar Year, the determination of whether the employer is a small or large employer shall be based on the average number of Employees that it is expected that the employer will employ on business days in the current Calendar Year.

☐ **I certify that I qualify as a Small Employer in the State of New Jersey.**

AND

☐ **I certify that the information provided to Horizon BCBSNJ and Horizon Healthcare of New Jersey is** information is not complete or is not provided to Horizon BCBSNJ and Horizon Healthcare of New Jersey in a timely manner, then health benefits coverage does not have to be offered or continued. I further understand that incomplete or untrue information may void health benefits coverage.

I understand that my employees and I may be subject to fines if an employee who is a resident of New Jersey and is eligible for coverage under this group health benefits plan is enrolled in an individual health benefits plan issued on or after August 1, 1993.

____

Signature of Officer, Partner, or Proprietor *Title* Date

____

Print Name of Officer, Partner, or Proprietor

____

Signature of Witness Date

☐ **I certify that I am NOT a Small Employer in the State of New Jersey, as defined above.**

____

Signature of Officer, Partner, or Proprietor *Title* Date

____

Print Name of Officer, Partner, or Proprietor

____

Signature of Witness Date

Any person who includes any false or misleading information on an application or enrollment form or certification for a health benefits plan is subject to criminal and civil penalties.

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COMPLETE THIS SECTION ONLY IF YOU HAVE CERTIFIED THAT YOU ARE A SMALL EMPLOYER IN THE STATE OF NEW JERSEY.

***EMPLOYEE CENSUS INFORMATION**

Please include the following persons in the following list:

a. employees, owners, partners, officers, and independent contractors who are actively working for the employer on a regular basis, and are paid by the employer on a regular basis, whether or not they are eligible to be covered under the policy.

b. employees, owners, partners, officers, and independent contractors who are not working, but who are currently covered under the employer's health benefits plan for reasons such as continuation of coverage or total disability.

Please use the following letters to indicate Status:

F: Full-time employee who works 25 or more hours per week
P: Part-time employee who works less than 25 hours per week
T: Temporary Employee
I: Independent Contractor
D: Totally Disabled Employee
C: Continuee under state or federal law
U: Employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement.

Name	Job Title	Date of Employment	Hours Worked Per Week	Status	Work Location (State)	Gender	Date of Birth
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							
16.							
17.							
18.							
19.							
20.							
21.							
22.							
23.							
24.							
25.							
26.							
27.							
28.							
29.							
30.							

*If additional space is needed, attach a separate sheet.

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Horizon Blue Cross Blue Shield of New Jersey

SMALL EMPLOYER HEALTH BENEFITS WAIVER OF COVERAGE

Group Policy No.: ___________________

Policyholder Name: ____

Employee Name: _________________________________ Social Security #: ________________
Last First MI

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Date of Employment: ___________________ Date of Birth: ___________________

I was given the opportunity to enroll in this plan of group health benefits offered by my employer and insured by Horizon Blue Cross Blue Shield of New Jersey, Inc. I *refuse* the following:

☐ Employee, Spouse, and Child(ren) coverage

☐ Spouse coverage

☐ Child(ren) coverage

Reason for Refusal (Please check all appropriate boxes.)

☐ other fully-insured Group Health Plan sponsored by this employer

☐ other Group Health Plan sponsored by my spouse's employer

☐ other group coverage sponsored by another organization

☐ covered under Medicare

☐ other reasons (please explain) ___________________________________

Please identify Group Health Plan(s) and provide names(s) of Policyholder(s), carrier(s) and policy number(s).

Policyholder/Name: ____

Carrier: ___________________________ Policy number: ________________

Policyholder/Name: ____

Carrier: ___________________________ Policy number: ________________

Policyholder/Name: ____

Carrier: ___________________________ Policy number: ________________

If you are declining enrollment for yourself or your dependents (including your spouse) because of other Group Health Plan coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents provided, that you request enrollment within 30 days after marriage, birth, adoption or placement for adoption.

If the reason for the refusal of coverage is coverage under another Group Health Plan, it is important to provide information concerning that Group Health Plan on this Waiver of Coverage form. If you fail to provide this information on this Waiver of Coverage form and you later become ineligible for such other coverage and then wish to enroll in any of the refused coverages, you will be considered a Late Enrollee and may be subject to the pre-existing conditions exclusion.

I understand that if I later wish to enroll for any of the coverage(s) refused, I will be required to submit an Enrollment Form and coverage may be subject to a pre-existing conditions exclusion.

___________________________________ ________________
Signature of Employee Date

___________________________________ ________________
Signature of Witness Date

2465 (W0904)

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Horizon Blue Cross Blue Shield of New Jersey

EMPLOYMENT VERIFICATION FOR HUSBAND/WIFE GROUPS

As a result of New Jersey Insurance Reform, mandated regulations govern the way in which Horizon Blue Cross Blue Shield of New Jersey issues and administers insurance policies. The criteria for eligibility regarding the creation and maintenance of a Small Group Plan may be found in Regulations @ N.J.A.C. 11:21 et seq.

I understand that pursuant to these Regulations, no individual shall become insured who is not a bona fide employee working on a full-time, compensated basis. Only full-time, compensated employees are eligible for coverage. A full-time compensated employee is one who regularly works at least 25 hours per week at the employer's place of business for compensation.

I, ____, do hereby certify that:

____ and ____ are

EMPLOYEES OF:____ which is

located at: ____ .

I further certify that both parties fully meet the definition of "full-time employee" as set forth by the State of New Jersey in Regulations @ N.J.A.C. 11:21 et seq.

I understand that if the information I have provided is not accurate, complete and true, or if I have omitted any facts or made any material misrepresentations of a fact, I may be in violation of N.J.S.A. 17B:27A-23 et seq. and 17:33A, New Jersey Fraud Prevention Act, as well as 2C:21-4.3.C, Healthcare Claims Fraud with criminal and civil penalties attached. In addition, I understand that if I omit material facts or provide false information my contract can be terminated as of the original effective date.

I have read this document and affix my signature.

______________________________ ______________________________

PRINT NAME – WIFE SIGNATURE DATE

______________________________ ______________________________

PRINT NAME – HUSBAND SIGNATURE DATE

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Horizon Blue Cross Blue Shield of New Jersey

NEW JERSEY SMALL EMPLOYER CERTIFICATION

For a policy of Group Health Benefits Insurance

Employer Name Group Policy No.

Address Street City State Zip

EMPLOYEE CENSUS INFORMATION

Please include the following persons in the following list:

a. Employees, owners, partners, officers, and independent contractors who are actively working for the employer on a regular basis, whether or not they are eligible to be covered under the policy.

b. Employees, owners, partners, officers, and independent contractors who are not working, but who are currently covered under the employer's health benefits plan for reasons such as continuation of coverage or total disability.

Please use the following letters to indicate Status:

F: Full-time employee who works 25 or more hours per week
P: Part-time employee who works less than 25 hours per week
T: Temporary Employee
I: Independent Contractor
D: Totally Disabled Employee
C: Continuee under state or federal law
U: Employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement.

Name	Job Title	Date of Employment	Hours Per Week	Status	Work Location (State)	Gender of Persons Waiving	Date of Birth Those Not Enrolling (Probationary period)
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							

If additional space is needed, attach a separate sheet, signed and dated.

SEE REVERSE

An Independent Licensee of the Blue Cross and Blue Shield Association

NEW JERSEY SMALL EMPLOYER CERTIFICATION (Continued)

CERTIFICATION AS A SMALL EMPLOYER IN THE STATE OF NEW JERSEY IN ACCORDANCE WITH NEW JERSEY CH. 162

Group Health Benefits Policy Participation (All Questions Must Be Answered)

An Eligible Employee is one who works on a full-time basis with a normal work week of 25 or more hours and for compensation. An employee who works less than 25 hours per week, on a temporary or substitute basis, or an employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement is not an eligible employee.

Total # Eligible Employees _________

Total # Eligible Employees applying / enrolling for health benefits coverage _________

Total # Eligible Employees waiving health benefits coverage under the policy with coverage under a spouse's coverage, other than individual coverage, or any Health Benefits Plan offered by the employer _________

Total # Eligible Employees waiving health benefits coverage under the policy without coverage under a spouse's coverage, other than individual coverage, or any Health Benefits Plan offered by the employer _________

Is your firm subject to Working Aged Provisions (TEFRA / DEFRA)? ☐ Yes ☐ No

Is your firm subject to the requirements of COBRA? ☐ Yes ☐ No

CERTIFICATION

Please sign and date the appropriate section indicating whether or not you meet the definition of a small employer.

Small Employer means, in connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that employed average of at least two but not more than 50 eligible Employees on business days during the preceding Calendar Year and who employs at least two Employees on the first day of the Plan Year, and the majority of the Employees are employed in New Jersey. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an employer that was not in existence during the preceding Calendar Year, the determination of whether the employer is a small or large employer shall be based on the average number of Employees that it is expected that the employer will employ on business days in the current Calendar Year.

I certify that I qualify as a Small Employer in the State of New Jersey.

I certify that the information provided is true and complete. I understand that if the above information is not complete or is not provided in a timely manner, then health benefits coverage does not have to be offered or continued. I further understand that incomplete or untrue information may void health benefits coverage.

I understand that I and my employees may be subject to fines if an employee who is a resident of New Jersey and is eligible for coverage under this group health benefits plan is enrolled in an individual health benefits plan issued on or after August 1, 1993.

Any person who includes any false or misleading information on an application or enrollment form or certification for health benefits plan is subject to criminal and civil penalties.

____

Signature of Officer, Partner, or Owner Title Date

____

Print Name of Officer, Partner, or Owner

____

Signature of Witness Date

____

I certify that I am not a Small Employer in the State of New Jersey, as defined above.

____

Signature of Officer, Partner, or Owner Title Date

____

Print Name of Officer, Partner, or Owner

____

Signature of Witness Date

Horizon Blue Cross Blue Shield of New Jersey

EMPLOYMENT VERIFICATION FORM FOR GROUPS TWO TO FIVE ELIGIBLE

As a result of New Jersey Insurance Reform, mandated regulations govern the way in which Horizon Blue Cross Blue Shield of New Jersey issues and administers insurance policies. The criteria for eligibility regarding the creation and maintenance of a Small Group Plan may be found in Regulations @ N.J.A.C. 11:21 et seq.

I understand that pursuant to these Regulations, no individual shall become insured who is not a bona fide employee working on a full-time, compensated basis. Only full-time, compensated employees are eligible for coverage. A full-time compensated employee is one who regularly works at least 25 hours per week at the employer's place of business for compensation.

I, ____, an Accountant/Attorney in the State of New Jersey, do hereby certify that I am the accountant for

____ Inc.

I am EMPLOYED by: (provide name, address and telephone number of firm)

____ .

I further certify that the following list of people are employees of the above listed company and fully meet the definition of "full-time employee" as set forth by the State of New Jersey in Regulations @ N.J.A.C. 11:21 et seq. The SEH reform policies, applications, etc. are standard forms published as Regulations @ N.J.A.C. 11:21 et seq., wherein the rules governing the reform market can be found.

1. ______________________________ 4. ______________________________

2. ______________________________ 5. ______________________________

3. ______________________________

(Attach additional sheet if required - sign each additional sheet.)

I further certify that the information I have provided is accurate, complete and true. I understand the omission of facts or the material misrepresentations of a fact, is a violation of N.J.S.A. 17B:27A-23 et seq. and 17:33A, New Jersey Fraud Prevention Act, as well as 2C:21-4.3.C, Healthcare Claims Fraud with criminal and civil penalties attached.

______________________________ ______________________ ______________

PRINT NAME SIGNATURE DATE

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Horizon Blue Cross Blue Shield of New Jersey

LATE PAPERWORK FORM

Agents: If you are submitting group enrollment paperwork 14 calendar days (or less) prior to the group's requested effective date, this form must be completed by the group administrator, signed and submitted with their **complete** paperwork to our offices.

Group: ____

Address: ____

We the undersigned understand that we are requesting a coverage date that will put our enrollment paperwork in Horizon BCBSNJ's home office(s) 14 days (or less) prior to our effective date, and that delivery of our ID cards and system activation will occur after our effective date.

Upon approval of our request for insurance, we acknowledge that the delivery of our group ID cards and system activation may occur after our effective date.

Name (please print): ______________________________________

Signature: ____

Date: ____

An Independent Licensee of the Blue Cross and Blue Shield Association

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

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 - 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			☐ ☐	/ /		Yes ☐		Yes ☐	Yes ☐
Spouse			☐ ☐	/ /		☐		☐	☐
Domestic Partner			☐ ☐	/ /		☐		☐	☐
Child			☐ ☐	/ /		☐		☐	☐
Child			☐ ☐	/ /		☐		☐	☐
Child			☐ ☐	/ /		☐		☐	☐

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.

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

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 / /

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.

Services and products may be provided by Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc., each of which is an indepenent licensee of the Blue Cross and Blue Shield Association.

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.

Horizon Blue Cross Blue Shield of New Jersey

SMALL EMPLOYER HEALTH BENEFITS WAIVER OF COVERAGE

Group Policy No. ________________

Policyholder Name: ____

Employee Name: ____
Last First MI

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Date of Employment: ______________________ Date of Birth: ______________________

I was given the opportunity to enroll in this plan of group health benefits offered by my employer and insured by Horizon Blue Cross Blue Shield of New Jersey, Inc. I *refuse* the following:

☐ Employee, Spouse, and Child(ren) coverage

☐ Spouse coverage

☐ Child(ren) coverage

Reason for Refusal (Please check all appropriate boxes.)

☐ other group coverage sponsored by this employer (Must provide carrier & group #) ________________

☐ other group coverage sponsored by my spouse's employer (Must provide carrier & group #) ____________

☐ other group coverage sponsored by another organization

☐ other reasons (please explain) ________________________________

Please provide name of carrier and policy number: ________________________________

I understand that if I later wish to enroll for any of the coverage(s) refused, I will be required to submit an Enrollment Form and coverage may be subject to a pre-existing conditions exclusion.

______________________________ ______________________
Signature of Employee Date

______________________________ ______________________
Signature of Witness Date

An Independent Licensee of the Blue Cross and Blue Shield Association