Horizon. Horizon Blue Cross Blue Shield of New Jersey

GROUP ENROLLMENT/CHANGE REQUEST

Mail to: Horizon BCBSNJ
Attn: Large and Mid-Size Group Enrollment
P.O. Box 10168
Newark, NJ 07101-3168
Email to: Midmajor_enrollment@horizonblue.com
Fax to: (973) 274-2297
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	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 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 _____

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. Your selection must be offered by your employer.

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

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

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

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

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

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

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)

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: _____