

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

Sub Group Number:	Data of Uiro	Group Number:/ / Effective Date/Date of Event://
Reason:	Date of Hire:/	/ Effective Date/Date of Event:/
. Type of Activity – to be completed by Emplo		
Refer to instructions before completing this form.		
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	1	
OVERAGE CONTINUATION		
For Employee Billing: 🖾 Group		
ate of Loss of Coverage	Qualifying Event #**	Date of Qualifying Event
/	· •	, , ,
☐ Total Disability*☐COBRA/NJSGC Length	of Continuation (in months):	8 29 *Attach proof of disability
For Spouse/Civil Union Partner*/Domestic Pa	rtner Billing: 🖾 Group	hand
Date of Loss of Coverage	Qualifying Event #**	Date of Occupied to a many
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C. Race/Ethnicity – to be completed by the Employee, at his/her	ontion	
NOTE: Your response is appreciated but NOT required! Choose a category that most	t classiv describes vous	* .
	of Hispanic origin	
Hispanic Asian or Pacific Islander White, not	of Hispanic origin	
D. Plan Option - to be completed by the Employee. Your selection	on must be offered by your emplo	ver.
Medical Check One: S F 2 Adults PC		- Andrie
Horizon Traditional Horizon Direct Access	Horizon Direct Access (HRA)	☐Horizon Advantage (EPO)
Horizon HMO Horizon PPO (HRA) Horizon POS Horizon PPO (HSA)	Horizon Direct Access (HSA)	Horizon Advantage EPO (HRA)
Horizon PPO OMNIA	☐ Horizon (EPO) ☐ OMNIA (HSA)	Horizon Advantage EPO (HSA)
Dental Check One: S F 2 Adults PC		
Horizon Dental Option Plan Horizon Dental PPO Plan	Horizon Dental PPO Access	
Horizon Healthy Smiles Horizon Healthy Smiles Plus		
Vision Check One: S F 2 Adults PC Horizon Expanse V Horizon Panorama III - ALT. A	Horizon Panorama IV - ALT. A	
Horizon Expanse VI Horizon Panorama III - ALT. B	Horizon Panorama III - ALT. B	Horizon Vista I Horizon Vista II
Horizon Expanse VII-A		Horizon Vista III
Horizon Expanse VII-B Horizon Expanse VIII		Horizon Vista IV
Horizon Expanse IV		
Prescription Check One: S F 2 Adults PC		
S = Single; F = Family; 2 Adults = Husband/Wife, Civil Union F	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/chair	nging/removing/continuing coverage.	Attach additional pages if
necessary, with your signature and dated. Attach proof of disability.		. 0
1. SPOUSE/CUP/DP	PUSE (COBRA/NJSGC) BRA/NJSGC) □ OTHER CHANGE	
Last Name, First Name, M.I.		
Social Security #	Date of Birth/	/Sex
Primary Care Provider Name		Current Patient Tyes TNo
NPI#	Loc Code	
Other Health Coverage Yes No, If Yes, Payer Name		
Policy #Me		
Home or billing address same as Employee? Yes No If No, C	omplete Section F2	
2. Child ADD REMOVE CONTINUATION OTHER		
Last Name, First Name, M.I.		
Social Security #	Date of Bidh	, ,
Primary Care Provider Name	Date of Bitti	Sex
NPI#	l oo Code	Current Patient YesNo
Other Health Coverage Yes No, If Yes, Payer Name	Loc Code	
Policy#	diama ID II II	
Policy # Me	dicare ID #, If any	
If last name is different from Employee's, please explain:		
3. Child ADD REMOVE CONTINUATION OTHER		
Last Name, First Name, M.I.		
Social Security #	Date of Birth/	/Sex
Primary Care Provider Name		Current Patient YesNo
NPI#	Loc Code	
Other Health Coverage Yes No, If Yes, Payer Name		
Policy # Me	dicare ID #, If any	
If last name is different from Employee's, please explain:		
Living with Employee? Tyes No. If No. Complete Section G		

1. Employer Name	Employer Phone	,		
Employer Address				
City	State	7in Cod	la	
2a. Home Address				
City				
2b.Please explain why the address is different:			16	
G. Additional Child Information – to be completed by Emp				
Provide information below about children listed in Section E, i an address, you may list them together. Attach additional page	if they have a different address from the e es as necessary, signed and dated.	mployee. If mu	ltiple child	ren are
Name				
Address			Apt	
City				
Reason:				
lame		·		
ddress			Apt	
dty	State	Zip Code	3	
Reason: LEmployee Signature represent that all the information supplied in this application in		***************************************		
Lemployee Signature represent that all the information supplied in this application is this Enrollment/Change Request form. I authorize deductions	s true and complete. I hereby agree to the s from my earnings for any contributions i	· Conditions of required from r	Enrollmen ne.	t set fo
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