Horizon℠

Horizon Blue Cross Blue Shield of New Jersey

GROUP ENROLLMENT/CHANGE REQUEST

Attn: Small Group Enrollment
P.O. Box 607 Department A
Newark, NJ 07101-0607
Fax (973) 274-2227
www.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: _____

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 30 *(please complete section B, if applicable)*	_____/_____/_____	_____
☐ 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 _____/_____/_____

☐ Total Disability* ☐ 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** Billing: ☒ Group

Date of Loss of Coverage _____/_____/_____ Qualifying Event #** _____ Date of Qualifying Event _____/_____/_____

☐ COBRA/NJSGC Length of Continuation (in months): ☐ 18 ☐ 29 ☐ 36

☐ Dependent Under 30 Billing: ☒ Home

Date of Loss of Coverage _____/_____/_____ Qualifying Event #** _____ Date of Qualifying Event _____/_____/_____

Home Address: _____

***Qualifying event #s: see list in Instructions.*

B. Additional Information for Dependent Under 30 Continuation Elections.

Provide information below about children listed in Section F for whom a Dependent Under 30 continuation election is being made.

This Continuation Election is being made:

☐ During an Open Enrollment period for the Over-Age Child based on his/her age-out anniversary

☐ Within 30 days prior to the attainment of the limiting age (when the Dependent will become an Over-Age Child)

☐ Within 30 days after the Over-Age Child has established eligibility for a Chapter 375 Continuation Election

C. 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 _____ Hours Per Week _____

State _____ Zip Code _____ 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 _____

Previous Coverage ☐ Yes ☐ No, If yes, Payer Name _____

Policy # _____ Effective Date ____/____/____ Termination Date ____/____/____

Submit a copy of the Certificate of Creditable Coverage

D. 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

E. Plan Option – to be completed by the Employee.

Check one Coverage Option Box and one Plan Option Box

Medical	☐ S	☐ F	☐ H/W	☐ CUP	☐ DP	☐ P/C
Dental	☐ S	☐ F	☐ H/W	☐ CUP	☐ DP	☐ P/C
Prescription	☐ S	☐ F	☐ H/W	☐ CUP	☐ DP	☐ P/C

☐ Horizon Traditional	☐ Horizon Direct Access	☐ Horizon Direct Access (HSA)
☐ Horizon POS	☐ Horizon PPO (HSA)	☐ Prescription
☐ Horizon PPO	☐ Horizon HMO	☐ Other _____

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

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.

F. 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 if full-time post-secondary student. Attach proof of disability.

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

Previous Coverage ☐ Yes ☐ No, If yes, Payer Name _____

Policy # _____ Effective Date ____/____/____ Termination Date ____/____/____

Employed? ☐ Yes ☐ No *If yes, Complete Section H1*

Submit a copy of the Certificate of Creditable Coverage

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 _____

Previous Coverage ☐ Yes ☐ No, If yes, Payer Name _____

Policy # _____ Effective Date ____/____/____ Termination Date ____/____/____

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

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

Submit a copy of the Certificate of Creditable Coverage

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 _____

Previous Coverage ☐ Yes ☐ No, If yes, Payer Name _____

Policy # _____ Effective Date ____/____/____ Termination Date ____/____/____

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

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

Submit a copy of the Certificate of Creditable Coverage

G. Preexisting Conditions – to be completed by Employee.

Complete if you are a new enrollee except when enrolling in a Small Employer Group health benefits plan with more than 5 employees. Complete for all late enrollees. If you check one of the conditions in #1, or respond yes to any question in #2, give details on a separate sheet of paper. This separate sheet must be signed and dated by you. 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 may only use the information to expedite the processing of claims.

1. If you or any dependent to be covered has been diagnosed as having any of the following within the past 6 months, please place a check mark in the appropriate box:

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

2. During the past 6 months, have you or any dependent to be covered:	Yes	No
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 medication?	☐	☐

H. Additional Spouse/CUP/DP Information – to be completed by Employee.

If not applicable mark as N/A.

Employer Name _____ Employer Phone _____

Employer Address _____

City _____ State _____ Zip Code _____

I. Additional Child Information – to be completed by Employee.

Provide information below about children listed in Section F, 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: _____

J. 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: ___/___/___

K. Over-Age Child's Signature

I represent that all the information supplied in this application regarding the Dependent Under 30 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 30 Continuation Election.

Signature: _____ Date: ___/___/___

L. Employer Verification

The requested activity is believed eligible and is approved by the Employer: ☐ Yes ☐ No

Employer Representative: _____ Date: ___/__/___

Representative's Title: _____

Instructions

Employers
You must complete the Employer Group Information and sections A, B, and L in order for this application to be processed.

Employees
You must complete sections C through J and submit the signature of each Over-Age Child for which a Dependent Under 30 Continuation Election is made in accordance with Section B 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 coverage beyond the limiting age, you do not have to make a COBRA/NJSGC or Dependent Under 30 election. Instead, select "Other" in Section A3, and attach proof of disability.
- If a dependent is a full-time post-secondary student, you must attach a current course schedule or a letter from the school or its authorized representative confirming full-time student status.
- You can obtain the providers' correct names and addresses 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.

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 (COBRA/NJSGC)

C4. Death of employee

C5. Loss of dependent child status under the plan.

C6. Disability (occurring subsequent to another qualifying event)

Dependent Under 30

D1. Loss of dependent status and otherwise eligible

D2. Reestablish eligibility: residency

D3. Reestablish eligibility: nonresident full-time student

D4. Reestablish eligibility: change in marital status

D5. Reestablish eligibility: change in parental status

D6. Reestablish 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 Blue Cross Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc., or any consumer reporting agency acting on behalf of Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc., 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 Blue Cross Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc. 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 Blue Cross Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc. 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 or placement for adoption, 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 or placement for adoption.

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. If you don't provide this statement, the above special enrollment rights may not be available to you if you need them.

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

General Notice of Preexisting Conditions Exclusions

NOTE: Your plan imposes a "preexisting conditions exclusion." As described below, the details of the exclusion that your plan has differ depending on the number of eligible employees in your group. Contact your benefits manager, if available, or employer for this information.

Small Employers with five or fewer eligible employees

A "preexisting conditions exclusion" means that if you or a covered dependent (if your plan includes coverage for dependents) has a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for the condition. This limitation only applies to a condition which manifests itself during the six-month period immediately preceding your or your dependent's enrollment date and for which medical advice, diagnosis, care or treatment was recommended or received during the six-month period immediately preceding that date.

The enrollment date means, with respect to an employee or dependent, the earlier of the effective date of his/her coverage under the group health plan, or the first day of the waiting period, if any, for such enrollment.

Small Employers with more than five eligible employees

In this case, your plan only imposes a preexisting conditions exclusion on employees and dependents (if the plan includes coverage for dependents) who are late enrollees. A late enrollee is:

- an employee or dependent (other than a newborn or an adopted child) who enrolls or is enrolled more than 30 days after first becoming eligible;
  or
- a newborn or adopted child whom you enroll more than 31 days after the child's birth, adoption or placement for adoption.

This means that if you or your dependent is a late enrollee and has a medical condition before coming to our plan, you will have to wait a certain period of time before the plan will provide coverage for that condition. This limitation only applies to a condition which manifests itself during the six-month period immediately preceding your or your dependent's enrollment date and for which medical advice, diagnosis, care or treatment was recommended or received during the six-month period immediately preceding that date. The "enrollment date" is the effective date of your or your dependent's coverage under the group health plan.

All Small Employers

A preexisting conditions exclusion does not apply to pregnancy. In addition, it does not apply to:

- a child who is covered under any creditable coverage within 31 days of birth adoption or placement of adoption as long as there is not a significant break in coverage of more than 90 consecutive days prior to the child's enrollment date;
  or
- birth defects in a covered dependent child.

This plan will not provide benefits for preexisting conditions for 180 days, measured from the person's enrollment date. However, the length of this period can be reduced by the number of days of your or your dependent's prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the length of this exclusion, provided that you or your dependent has not experienced a break in coverage of 90 days or more.

To reduce the length of this exclusion by creditable coverage, you must provide the plan with a copy of any certificates of creditable coverage that you have. There are also other ways that you can prove prior creditable coverage.

If you have questions about the preexisting conditions exclusion, or if you need help demonstrating creditable coverage, contact your benefits manager, if available, or your employer.

Notice on Dependent Under 30 Continuation

Horizon Blue Cross Blue Shield of New Jersey will bill over- age dependents directly and enrollees will remit the premium directly to Horizon. When Dependent Under 30 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.