Horizon.

Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work.

SMALL GROUP ENROLLMENT/ CHANGE REQUEST

Mail to: Horizon BCBSNJ
Attn: Small Group Enrollment
P.O. Box 807 Department A
Newark, NJ 07101-0807
Email to: small_group_maintenance_enrollment_team@HorizonBlue.com
Fax (973) 274-2227
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 for Change: _____

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 31 *(please complete Coverage Continuation section)*	____/____/____	
☐ 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 ____/____/____

☐ 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 _____

Dentist Office ID number (if applicable) _____ Current Patient ☐ Yes ☐ No

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. Please refer to the instructions for available continuation rights.

Medical Plan Option *Check One:*

☐ Horizon Advantage Direct Access ☐ PCMH Advantage EPO
☐ Horizon Advantage Direct Access (HSA) ☐ OMNIA
☐ Horizon Advantage EPO (HSA) ☐ OMNIA (HSA)
☐ Horizon Advantage EPO ☐ Other _____

Select one coverage option: ☐ S ☐ F ☐ H/W ☐ CUP ☐ DP ☐ P/C

Pediatric Dental and Family Pediatric Dental *Check One:*

☐ Horizon Young Grins (only provides benefits for members under 19)
☐ Horizon Family Grins
☐ Horizon Family Grins Plus

Select one coverage option: ☐ S ☐ F ☐ H/W ☐ CUP ☐ DP ☐ P/C

Family Dental *Check One:*

☐ Horizon Dental Option Plan ☐ **Horizon Dental Choice**
☐ Horizon Dental PPO ☐ **Horizon Healthy Smiles**
☐ Horizon Dental PPO Access ☐ **Horizon Healthy Smiles Plus**
☐ Horizon Dental Companion

Select one coverage option: ☐ S ☐ F ☐ H/W ☐ CUP ☐ DP ☐ P/C

Vision Plan Option *Check One:*

☐ Horizon Expanse V ☐ **Horizon Panorama IV (Alt A)** ☐ **Horizon Vista II**
☐ Horizon Expanse VII (Alt A) ☐ **Horizon Panorama IV (Alt B)** ☐ **Horizon Vista III**
☐ Horizon Expanse VII (Alt B) ☐ **Horizon Vista IV**
☐ Horizon Expanse VIII

Select one coverage option: ☐ S ☐ F ☐ H/W ☐ CUP ☐ DP ☐ P/C

S = Single F = Family H/W = Husband/Wife CUP = Civil Union Partners DP = 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.

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

Dentist Office ID number (if applicable) _____ **Current Patient** ☐ **Yes** ☐ **No**

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

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 _____

Dentist Office ID number (if applicable) _____ Current Patient ☐ Yes ☐ No

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

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

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 _____

Dentist Office ID number (if applicable) _____ Current Patient ☐ Yes ☐ No

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 _____

Dentist Office ID number (if applicable) _____ Current Patient ☐ Yes ☐ No

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 _____

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: _____