Horizon Blue Cross Blue Shield of New Jersey

GROUP ENROLLMENT/CHANGE REQUEST

You may complete the required fields below online and then save or print a copy for submission. To save a completed copy to your computer, choose File > Save As to rename the file and save the form with your information to your computer.

Attn: Large and Mid-Size Group Enrollment
P.O. Box 10168
Newark, NJ 07101-3168
Fax (973) 274-2297
www.HorizonBlue.com

Group Information – to be completed by Employer.

Group Name: Nutley BOE Group Number: 86015
Sub Group Number: ______
Date of Hire: ___/___/___ Effective Date/Date of Event: 1/1/13
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
☐ 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 Event ___/___/___

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 ______

Previous Coverage ☐ Yes ☐ No, If Yes, Payer Name ______

Policy # ______ Effective Date ___/___/___ Termination Date ___/___/___

Submit a copy of the Certificate of Creditable Coverage

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 ☐

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

☐ Horizon Dental

☐ Horizon Direct Access

☐ Horizon Advantage EPO

S = Single; F = Family; 2 Adults = Husband/Wife, Civil Union Partners or 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.

Clear Page 1

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 ____________

Previous Coverage ☐ Yes ☐ No, If Yes, Payer Name ____________

Policy # ____________ Effective Date ___/___/___ Termination Date ___/___/___

Employed? ☐ Yes ☐ No *If Yes, Complete Section F1*

Home or billing address same as Employee? ☐ Yes ☐ No *If No, Complete Section F2*

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 G*

Submit a copy of the Certificate of Creditable Coverage

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 ____________

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 G*

Submit a copy of the Certificate of Creditable Coverage

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: ____________

Instructions

Employers

You must complete the Group Information and sections A and J in order for this application to be processed.

Employees

You must complete sections B through I and submit the signature of each Over-Age Child for which a Dependent Under 31 Continuation Election is made in accordance with Section J 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 age 26, you do not have to make a COBRA/NJSGC or Dependent Under 31 election. Instead, select "Other" in Section A, and attach proof of disability.
- You can obtain the providers' correct names 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) if covered under group benefits

C4. Death of employee

C5. Loss of dependent child status under the plan.

C6. Disability (occurring subsequent to another qualifying event)

Dependent Under 31

D1. Loss of dependent status (aged out) and otherwise eligible

D2. Re-establish eligibility: residency

D3. Re-establish eligibility: nonresident full-time student

D4. Re-establish eligibility: change in marital status

D5. Re-establish eligibility: change in parental status

D6. Re-establish 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.

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 are independent licensees of the Blue Cross and Blue Shield Association.

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 or plan provider stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the other employer or plan provider stops contributing toward the other coverage).

In addition, if your 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 marriage, birth, adoption or placement for adoption.

If you decline coverage under this plan, you may be asked to state in writing whether the declination was due to the existence of other health coverage. If this is so and you don't provide the 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 department or personnel representative.

Notice on Dependent Under 31 Continuation

Horizon Blue Cross Blue Shield of New Jersey will bill over- age dependents directly and enrollees will remit the premium directly to Horizon BCBSNJ. When Dependent Under 31 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.