



Horizon Blue Cross Blue Shield of New Jersey

GROUP ENROLLMENT/CHANGE REQUEST

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: _____ 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.

<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE <input type="checkbox"/> OTHER CHANGE	Effective Date/Date of Event	Reason for Change
<input type="checkbox"/> Subscriber	____/____/____	_____
<input type="checkbox"/> Spouse	____/____/____	_____
<input type="checkbox"/> Civil Union Partner (CUP)	____/____/____	_____
<input type="checkbox"/> Domestic Partner (DP)	____/____/____	_____
<input type="checkbox"/> Dependent Child	____/____/____	_____
<input type="checkbox"/> Over-Age Child as a Dependent Under 31 <small>(and complete Coverage Continuation section)</small>	____/____/____	_____
<input type="checkbox"/> Name Change	____/____/____	_____
<input type="checkbox"/> Change Plan	____/____/____	_____
<input type="checkbox"/> Other	____/____/____	_____
<input type="checkbox"/> 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 #: 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 ____/____/____

Hours Worked _____ City _____ State _____ Zip Code _____

Employer Address _____

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 _____

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 Advantage EPO

Horizon Direct Access **1 4** (circle one)

Dental Check One: S F 2 Adults PC

Horizon Dental

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.

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: _____