



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: \_\_\_\_\_

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
<input type="checkbox"/> Subscriber	____/____/____	_____
<input type="checkbox"/> Spouse	____/____/____	_____
<input type="checkbox"/> Civil Union Partner (CUP)/Domestic Partner (DP)	____/____/____	_____
<input type="checkbox"/> Dependent Child	____/____/____	_____
<input type="checkbox"/> Over-Age Child as a Dependent Under 30 <i>(please complete section B, if applicable)</i>	____/____/____	_____
<input type="checkbox"/> Name Change	____/____/____	_____
<input type="checkbox"/> Change Plan	____/____/____	_____
<input type="checkbox"/> 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 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 #: 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 H*

*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:**

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

**2. During the past 6 months, have you or any dependent to be covered:**

- |  |                          |                          |
|--|--------------------------|--------------------------|
| a. been examined or treated by a physician or other health care provider for any condition, illness or injury, other than as stated above? | Yes                      | No                       |
| b. been advised to have treatment or surgery or testing that has not been done?  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. been admitted to a hospital or other health care facility as an inpatient?  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. taken prescribed medication?  | <input type="checkbox"/> | <input type="checkbox"/> |

**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 A, 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](http://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.