Enrollment Form

Horizon Blue Cross Blue Shield of New Jersey

1. Please read the instructions on the back page before completing this enrollment form.

2. Please print clearly.

3. You must sign and date the enrollment form.

Horizon Blue Cross Blue Shield of New Jersey

NON-GROUP ENROLLMENT/CHANGE REQUEST

Attn: Consumer Enrollment Dept.
P.O. Box 1330
Newark, NJ 07101-1330
www.horizonblue.com

A. Type of Activity – to be completed by Applicant *Check all that apply*

1. ADD

	Effective Date/Date of Event	Reason		Effective Date/Date of Event	Reason
☐ Enrollment of a new Subscriber	____/____/____	____________	☐ Add Domestic Partner	____/____/____	____________
☐ Add Spouse	____/____/____	____________	☐ Add Dependent Child	____/____/____	____________
☐ Add Civil Union Partner	____/____/____	____________			

2. REMOVE

☐ Remove Subscriber	____/____/____	____________	☐ Remove Domestic Partner	____/____/____	____________
☐ Remove Spouse	____/____/____	____________	☐ Remove Dependent Child	____/____/____	____________
☐ Remove Civil Union Partner	____/____/____	____________			

3. OTHER CHANGE

☐ Name Change	____/____/____	____________	☐ Change Plan	____/____/____	____________
☐ Add/Change Office ID Numbers: Primary Care Provider	____/____/____	____________	☐ Other	____/____/____	____________

B. Applicant Information ☐ Add ☐ Remove ☐ Other Change ☐ Continue *If a name change, indicate prior name:* ____________

Last Name: First Name: MI:

Social Security #: Date of Birth: (MM DD YYYY) Sex: (M F)

Are you a resident of New Jersey? ☐ Yes ☐ No

Primary Residence: Street Apt.:

City: State: Zip Code: Home Phone: E-Mail Address:

Do you maintain a home in any other state? ☐ Yes ☐ No *If yes:* Name of State: ____________ Number of months you live there each year: ____________

Other Residence: Street Apt.:

City: State: Zip Code: Home Phone:

Your billing address: ☐ Primary residence ☐ Other residence ☐ P.O. Box or Other *(specify)*: ____________

Primary Care Provider Name: Current Patient: ☐ Yes ☐ No

Primary Care Provider Address:

City: State: Zip Code + 4:

NPI #: Loc Code:

Are you covered under Other Health Coverage? ☐ Yes ☐ No *If yes:* Payer Name: ____________

Policy #: Medicare ID#, if any:

Why are you applying for individual coverage? ____________

Are you **eligible but not covered** under Other Health Coverage? ☐ Yes ☐ No *If yes, what is it?*

☐ Group plan via employment *(specify payer)*: ____________

☐ Medicaid/NJFamilyCare ☐ Medicare ☐ Other *(specify)*: ____________

Previous Coverage? ☐ Yes ☐ No *If yes:* Payer Name; ____________

Policy #: Effective Date: (MM DD YYYY) Termination Date: (MM DD YYYY) *Submit a copy of the Certificate of Creditable Coverage*

What was it?
☐ Individual ☐ Group
☐ Medicaid/NJFamilyCare
☐ Other *(specify)*: ____________

What Plan Type?
☐ Indemnity ☐ PPO ☐ POS ☐ HMO
☐ Other *(specify)*: ____________

Cost-sharing requirements:
Deductible Amount: $ ____________
Coinsurance Amount: ____________%
Copayment Amount: $ ____________

Did coverage terminate as a result of fraud or failure to pay premiums?	☐ Yes	☐ No
Were you allowed to make a COBRA continuation election, or a continuation election under State law, if any, when coverage ended?	☐ Yes	☐ No
If yes, did you elect to continue and remain covered for the entire continuation period available to you?	☐ Yes	☐ No
Were you covered for 18 months or more under any previous plan(s)?	☐ Yes	☐ No
Have you experienced more than a 63-day break in coverage between any previous plan, including your most recent plan and the date of this application?	☐ Yes	☐ No

POLICYHOLDER'S LAST NAME, FIRST NAME, AND MI ______________________________

C. Plan Option *Check One*

☐ Single ☐ Family ☐ Husband & Wife, Domestic Partners or Civil Union Partners ☐ Adult & Child

A/50 ☐ Basic Deductible $1000 ____ $2500 ____ $5000 ____ $10000 ____

Plan B ☐ Traditional Deductible $1000 ____ $2500 ____

Plan C ☐ Traditional Deductible $1000 ____ $2500 ____ ☐ High Deductible $1500 ____ $2250 ____ per individual
$3000 ____ $4500 ____ per family
☐ Inflation Adjusted Deductible $1900 ____ $2850 ____ per individual
$3750 ____ $5650 ____ per family

Plan D ☐ Traditional Deductible $1000 ____ $2500 ____ ☐ High Deductible $1500 ____ $2250 ____ per individual
$3000 ____ $4500 ____ per family
☐ Inflation Adjusted Deductible $1950 ____ $2900 ____ per individual
$3850 ____ $5800 ____ per family

HMO Plan:

☐ $15 Copayment ☐ $30 Copayment ☐ $30 PCP/$50 Specialist Copayment ☐ $50 PCP/$70 Specialist Copayment ☐ $2500 Deductible/50% Coinsurance

☐ Basic and Essential EPO ☐ Basic and Essential EPO Plus

D. Other Individuals Covered

Identify individuals other than yourself for whom you are adding/changing/removing coverage. Attach additional pages if necessary, dated and signed by you. Attach proof if full-time post-secondary student. Attach proof of disability.

1. SPOUSE/CIVIL UNION PARTNER/DOMESTIC PARTNER ☐ Add ☐ Remove ☐ Other

Last Name: First Name: MI:

Social Security #: Date of Birth: (MM DD YYYY) Sex: M F

Employed ☐ Yes ☐ No *If Yes, complete section F1* Home address same as Applicant ☐ Yes ☐ No *If No, complete section F2*

Primary Care Provider Name: Current Patient Yes No

Primary Care Provider Address:

City: State: Zip Code + 4:

NPI #: Loc Code:

Previous Coverage ☐ Yes ☐ No *If yes:* Payer Name: ______________________________

Policy #: Effective Date: (MM DD YYYY) Termination Date: (MM DD YYYY)

Submit a copy of the Certificate of Creditable Coverage

What was it?

☐ Individual ☐ Group

☐ Medicaid/NJFamilyCare

☐ Other *(specify)*: ______________________________

What Plan Type?

☐ Indemnity ☐ PPO ☐ POS ☐ HMO

☐ Other *(specify)*: ______________________________

Cost-sharing requirements:

Deductible Amount: $ ______________________

Coinsurance Amount: ______________________%

Copayment Amount: $ ______________________

Why did coverage end? ______________________________

Was continuation upon termination an option? ☐ Yes ☐ No If yes, was continuation elected and coverage retained for full continuation period? ☐ Yes ☐ No

Does total previous coverage equal 18 months or more? ☐ Yes ☐ No Any breaks in coverage of more than 63 days? ☐ Yes ☐ No

Covered under Other Health Coverage now? ☐ Yes ☐ No *If yes:* Payer Name: ______________________________

Policy #: Medicare ID#:

Eligible but not covered under Other Health Coverage? ☐ Yes ☐ No *If yes, identify the type:*

☐ Group Payer: ______________________________

☐ Medicaid/NJFamilyCare ☐ Medicare ☐ Other *(specify)*: ______________________________

POLICYHOLDER'S LAST NAME, FIRST NAME, AND MI ____________________

2. CHILD ☐ Add ☐ Remove ☐ Other

Last Name: First Name: MI:

Social Security #: Date of Birth: MM DD YYYY Sex: M F

If last name is different from applicant's please explain: ____________________ Living with Applicant? ☐ Yes ☐ No *If No, complete Section G*

Primary Care Provider Name: Current Patient: Yes No

Primary Care Provider Address:

City: State: Zip Code + 4:

NPI #: Loc Code:

Previous Coverage? ☐ Yes ☐ No *If yes:* Payer Name: ____________________

Policy #: Effective Date: MM DD YYYY Termination Date: MM DD YYYY *Submit a copy of the Certificate of Creditable Coverage*

What was it?
☐ Individual ☐ Group
☐ Medicaid/NJFamilyCare
☐ Other *(specify)*: ____________________

What Plan Type?
☐ Indemnity ☐ PPO ☐ POS ☐ HMO
☐ Other *(specify)*: ____________________

Cost-sharing requirements:
Deductible Amount: $ ____________________
Coinsurance Amount: ____________________%
Copayment Amount: $ ____________________

Why did coverage end? ____________________
Was continuation upon termination an option? ☐ Yes ☐ No If yes, was continuation elected and coverage retained for full continuation period? ☐ Yes ☐ No
Does total previous coverage equal 18 months or more? ☐ Yes ☐ No Any breaks in coverage of more than 63 days? ☐ Yes ☐ No

Covered under Other Health Coverage now? ☐ Yes ☐ No *If yes:* Payer Name: ____________________

Policy #: Medicare ID#:

Eligible but not covered under Other Health Coverage? ☐ Yes ☐ No *If yes, identify the type:*
☐ Group Payer: ____________________ ☐ Medicaid/NJFamilyCare ☐ Medicare ☐ Other *(specify)*: ____________________

3. CHILD ☐ Add ☐ Remove ☐ Other

Last Name: First Name: MI:

Social Security #: Date of Birth: MM DD YYYY Sex: M F

If last name is different from applicant's please explain: ____________________ Living with Applicant? ☐ Yes ☐ No *If No, complete Section G*

Primary Care Provider Name: Current Patient: Yes No

Primary Care Provider Address:

City: State: Zip Code + 4:

NPI #: Loc Code:

Previous Coverage? ☐ Yes ☐ No *If yes:* Payer Name: ____________________

Policy #: Effective Date: MM DD YYYY Termination Date: MM DD YYYY *Submit a copy of the Certificate of Creditable Coverage*

What was it?
☐ Individual ☐ Group
☐ Medicaid/NJFamilyCare
☐ Other *(specify)*: ____________________

What Plan Type?
☐ Indemnity ☐ PPO ☐ POS ☐ HMO
☐ Other *(specify)*: ____________________

Cost-sharing requirements:
Deductible Amount: $ ____________________
Coinsurance Amount: ____________________%
Copayment Amount: $ ____________________

Why did coverage end? ____________________
Was continuation upon termination an option? ☐ Yes ☐ No If yes, was continuation elected and coverage retained for full continuation period? ☐ Yes ☐ No
Does total previous coverage equal 18 months or more? ☐ Yes ☐ No Any breaks in coverage of more than 63 days? ☐ Yes ☐ No

Covered under Other Health Coverage now? ☐ Yes ☐ No *If yes:* Payer Name: ____________________

Policy #: Medicare ID#:

Eligible but not covered under Other Health Coverage? ☐ Yes ☐ No *If yes, identify the type:*
☐ Group Payer: ____________________ ☐ Medicaid/NJFamilyCare ☐ Medicare ☐ Other *(specify)*: ____________________

POLICYHOLDER'S LAST NAME, FIRST NAME, AND MI ______________________________

E. Preexisting Conditions.

Check all that apply. 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
- ☐ b. Arthritis
- ☐ c. Blood Disorder
- ☐ d. Back or Neck Disorder, Injury or Pain
- ☐ e. Cancer or Tumors
- ☐ f. Diabetes
- ☐ g. Gastro or Intestinal Disorder
- ☐ h. Heart Disorder/Condition /Chest Pain
- ☐ i. High Blood Pressure
- ☐ j. Kidney or Liver Disorder
- ☐ k. Lung or Respiratory Disorder
- ☐ l. Mental or Nervous Disorder
- ☐ m. Paralysis, Stroke or Epilepsy
- ☐ n. Does a pregnancy exist?

If so, provide expected due date: ____________

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?	☐	☐

F. Additional Spouse/Civil Union Partner/Domestic Partner Information

If not applicable, please mark as "NA."

1. Employer Name: Employer Phone:

Employer Address:

City: State: Zip Code:

2a. Home Address:

City: State: Zip Code:

2b. Please explain why the address is different: ______________________________

G. Additional Child Information

Provide information below about children listed in Section D, if they have a different address. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.

Name:

Street: Apt:

City: State: Zip Code:

Reason: ______________________________

Name:

Street: Apt:

City: State: Zip Code:

Reason: ______________________________

H. Race/Ethnicity

Your response is appreciated but NOT required. Choose a category that most closely describes you:

- ☐ American Indian or Alaskan Native
- ☐ Asian or Pacific Islander
- ☐ Black, not of Hispanic origin
- ☐ White, not of Hispanic origin
- ☐ Hispanic

I. Payment Information

Indicate how you would like to make payment

☐ Check ☐ Money Order ☐ Automatic Bank Draft (attach voided check)

☐ Credit Card Type (☐ Visa ☐ Mastercard) No.: ______________________________ Exp. Date: ________/________

Cardholder Name: ______________________________

J. Applicant's 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.

Signature: ______________________________ Date: ______/______/_____

K. Broker/General Agent Signature

Signature of Preparer: ______________________________ Date: ______/______/______ NJ Producer License #: ______________

General Agent/Broker: ______________________________ Agent/Vendor ID# ____________________

Instructions

INSTRUCTIONS AND ELIGIBILITY REQUIREMENTS

Instructions

- Except for section H, you must complete sections A through J, and sign and date this form, as well as any additional pages you may need to submit with it to provide further requested information.
- Please PRINT except when a signature is requested.
- If a dependent child is disabled and you want to continue his or her coverage beyond the limiting age, describe this in “Other Change” 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 number and LOC Code from the appropriate 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.
- For provider addresses, include the zip code plus the four digit extension (11 digits).
- “Previous Coverage” and “Other Health Coverage” includes coverage under a: group health plan resulting from employment, whether with a private or public (governmental) employer, including such coverage continued through a COBRA election or state continuation provisions; a church plan, Medicare, Medicaid, NJFamilyCare or another individual health benefits plan.
- IF YOU HAVE ANY QUESTIONS concerning the benefits and services provided by or excluded under this policy, contact a Horizon Blue Cross Blue Shield of New Jersey Sales representative at 800-224-1234 or your broker before signing this form.
- KEEP A COPY OF THIS COMPLETED APPLICATION! A copy of this application may be used as a temporary ID card for 30 days from the effective date if authorized by Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc. Coverage must be verified with Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc. prior to visiting with a physician or admission to a hospital.

Eligibility

A. Eligibility requirements are set forth under the Individual Health Coverage Reform Act of 1992, P.L. 1992, c. 161 (N.J.S.A. 17B:27A-2 et seq.).

B. You MUST be a New Jersey resident.

C. EXCEPT as F. below applies, you and family members you wish to cover MUST NOT be eligible to be covered under a: group health plan; a group health benefits plan; a governmental plan (not including Medicaid); a church plan; or Medicare.

D. You and any family members you wish to cover are NOT eligible for a standard individual health benefits plan if covered by another individual health benefits plan UNLESS you are replacing the other individual health benefits plan by the one for which you are submitting this application.

E. If you do not specify an effective date in the application, your effective date shall be no later than the first day of the month following the month in which the completed application was dated and we receive premium payment directly or through our duly authorized agent UNLESS you submit your application during the November Open Enrollment Period (see F. below).

F. You may apply for coverage for yourself and family members who are covered under a group health plan, group health benefits plan, a governmental plan, or a church plan during the November Open Enrollment Period, if you wish to replace the current coverage with a more comprehensive individual health benefits plan. The effective date of coverage under the individual health benefits plan in this instance will be January 1 of the calendar year following the November Open Enrollment Period. You SHOULD NOT terminate current coverage until the new coverage is effective.

CONDITIONS OF ENROLLMENT - APPLICANT ACKNOWLEDGES 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 individual plan.
5. I understand that my enrollment and the enrollment of my listed dependents in Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc.’s individual plan is effective upon acceptance by Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc.
6. 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 individual policy if premiums are not paid timely.

Misrepresentations

Any person who includes any false or misleading information on a Nongroup 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.