Horizon Blue Cross Blue Shield of New Jersey

Small Employer Group Application Instructions

Instructions

The attached forms should be completed with the assistance of your authorized Broker or Horizon Blue Cross Blue Shield of New Jersey Sales Representative.
Please complete all necessary forms in their entirety. Please print in ink or type your responses.

Ensure that all areas requiring a **signature and date are complete.** The Officer, Partner, Owner and / or Correspondent signing the application must be listed on the New Jersey Small Employer Certification.

Completed enrollment application forms should be sent to your authorized Broker or Horizon BCBSNJ Sales Representative **prior to your effective date.**

Documents Included

Attached you will find the forms that must be completed and submitted for each New Jersey small employer group applying for standard health insurance coverage:

- Application for a Small Employer Health Benefits Policy.
- New Jersey Small Employer Certification.
- Small Employer Health Benefits Waiver of Coverage – One form is needed for each employee waiving or refusing coverage. This form may be photocopied as needed.

Other Required Documents

In addition to the forms listed above, **depending on group size / composition and preferred payment method, the following items may also be required:**

- Payroll verification through appropriate tax documentation, i.e., WR30 (required for groups of two to five eligibles).
- Spousal Business Statement (required for husband and wife-only groups) (#3268).
- Automatic Pay Plan Application (#8977).

When submitting your paperwork as required above, **you must also submit the following:**

- Enrollment Change / Request Form (#6803) – One form is needed for each employee enrolling. Your authorized Broker or Horizon BCBSNJ Sales Representative will provide these forms.
- First month's premium – All new cases must be submitted with a company check for the first month's premium payable to Horizon BCBSNJ. If a case is submitted without a premium check, the case will be returned.
- Prior / Current Carrier's most recent billing statement – Required if replacing group medical coverage.
- Rate Quote – The rate quote generated for the group should match the product(s) selected in Section II of the Application for a Small Employer Health Benefits Policy.

Rate Quotes

The rate quote is an estimate based on information provided by your authorized Broker or Horizon BCBSNJ Sales Representative. If there is inaccurate or missing information on the original quote, the rate may change based on an official review of the paperwork submitted to Horizon BCBSNJ.

Mailing Instructions

Please send the completed paperwork and attachments to:

Horizon Blue Cross Blue Shield of New Jersey
Three Penn Plaza East PP-09W
Newark, NJ 07105-2200

Horizon Blue Cross Blue Shield of New Jersey

APPLICATION FOR A SMALL GROUP HEALTH BENEFITS POLICY

Please print or type Policy Number _____ ☐ New Policy ☐ Change in Policy Requested Effective Date _____

Note: The Effective Date will be on or after the date Horizon Blue Cross Blue Shield of New Jersey approves the application.

SECTION I: POLICYHOLDER INFORMATION

1. Policyholder (full legal name of company): _____

2. Tax Identification Number: _____

3. Main Address: _____
   Street City State ZIP

   Mailing Address: _____
   Street City State ZIP

   Telephone: _____ Fax: _____ Email Address: _____

4. Name of Correspondent: _____ Title: _____

5. Type of Organization: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Other (explain): _____

6. Nature of Business (specify): _____ SIC Code: _____

7. Number of eligible employees in your company: _____
   Refer to the New Jersey Small Employer Certification for the definition of an eligible employee.

8. Number of eligible employees to be insured: _____ 9. Class or classes to be excluded: _____

10. Insurance Requested For: ☐ Employees Only ☐ Employees and Dependents
    Should the plan provide coverage for domestic partners as permitted by P.L. 2003, c. 246? ☐ Yes ☐ No
    If yes, should the plan provide coverage for coverage of children of a covered domestic partner? ☐ Yes ☐ No

11. Is the employer subject to the requirements of COBRA? ☐ Yes ☐ No

12. Is the employer subject to the requirements of Medicare as Secondary Payor Rules for eligibility due to age? ☐ Yes ☐ No
    Due to disability? ☐ Yes ☐ No

13. Waiting period before employees become insured: (may not exceed 6 months) Present Employees : _____ New or Rehired Employees: _____

14. What percentage of the premium will the employer pay? _____ 15. Deposit $ _____

Premium Paid: ☐ Monthly ☐ Quarterly ☐ Automatic checking withdrawal
Premium will be due as of the effective date. The premium for the first month of coverage must be attached.

Affiliates, subsidiaries or branches (Must be included for purposes of participation)

Legal Name & Location	No. of eligible employees in this company	No. of eligible employees to be insured

SECTION II: SPECIFICATIONS FOR COVERAGE

Health Benefits

Copayment Options (select one): ☐ **$20** ☐ **$30** ☐ **$50** ☐ **$20/40** ☐ **$25/50** ☐ **$30/50**

☐ **SE Horizon Advantage EPO**

Plan Description _____

☐ **SE Horizon HMO** ☐ **SE Horizon HMO Access** ☐ **SE Horizon HMO Access Coinsurance**

Plan Description _____

☐ **SE Direct Access Advantage**

Plan Description _____

☐ **SE PPO Advantage**

Plan Description _____

☐ **SE HSA Compatible Direct Access CDHRx**

Plan Description _____

☐ **SE HSA Mellon Direct Access CDHRx**

Plan Description _____

☐ **SE HSA Compatible PPO CDHRx**

Plan Description _____

☐ **SE HSA Mellon PPO CDHRx**

Plan Description _____

☐ **SE HSA Compatible HMO Access CDHRx**

Plan Description _____

☐ **SE HSA Mellon HMO Access CDHRx**

Plan Description _____

☐ SE Comprehensive Plan A Ded $250 MP $7750

☐ SE PPO 100/60 C50/50 D0/5000 M5000/10000
☐ SE POS 100/70 C50/50 D0/5000 M5000/10000
☐ SE POS 100/60 C50/50 D0/5000 M5000/10000
☐ SE Adv EPO 100/80 C50/50 D250 M5000

Prescription Drug (select one):

The prescription plan options below have exclusions beyond the standard drug plan exclusions:

☐ Retail: $10 / $20 / $35 Mail Order: $30 / $60 / $105

☐ Retail: $12 / $25 / $40 Mail Order: $24 / $50 / $80 No Deductible. This option available for Horizon HMO only.

☐ Retail: $10 / $25 / $50 Mail Order: $20 / $50 / $100

☐ Retail: $10 / 30% / 50% Mail Order: $20 / 60% / 100%

☐ Retail: $10 / $35 / $70 Mail Order: $20 / $70 / $140

☐ 50% Coinsurance

☐ $15 / 50% Mail Order: $30 / 50%

☐ $14 / $40 / $75 Mail Order: $30 / $100 / $200

☐ One-Bill Option ... Select this option when purchasing multiple health products and one summary billing statement is requested.

AGENT PRODUCER INFORMATION (THIS INFORMATION MUST BE ANSWERED COMPLETELY)

BROKER SIGNATURE _____ DATE _____ VENDOR NUMBER _____

BROKER-NAME _____ NAME OF AGENCY _____ TELEPHONE NUMBER _____

STREET _____ CITY _____ STATE _____ ZIP CODE _____

OTHERS (NAME, TITLE) _____

SPECIAL INSTRUCTIONS _____

FOR INTERNAL UNDERWRITING USE

☐ Approved for _____ Number of Subscribers _____

☐ Declined

Band _____ Date _____

Underwritten By _____ Pre-Ex Applies ☐ Yes ☐ No

FOR INTERNAL GROUP ENROLLMENT USE

	ADV EPO	HMO	POS	DA	PPO	HSA	A	Rx	Dental
COVERAGE CODE c/o									
TOTAL APPLICATIONS SUBMITTED									
TRANSFER FROM GROUP # _____									
REFUSALS/WAIVERS LISTING ATTACHED (IF APPLICABLE)									
EMPLOYER CONTRIBUTION									
EFFECTIVE DATE									
FUTURE RATE RENEWAL DATE									

APPROVED BY: _____ _____

ACCOUNT CONSULTANT SIGNATURE DATE APPROVED

SECTION III: ALL QUESTIONS MUST BE ANSWERED

1. Is there any Group Health Plan:
   - now in force and to be continued? ☐ Yes ☐ No
   - currently being applied for? ☐ Yes ☐ No

   If "Yes", identify the name of the Group Health Plan, give a description of the plan(s) and name of insurance carrier(s)_____

   _____

2. Name of present or prior group carrier _____

   Effective date of prior coverage _____ Cancellation/termination date _____

   Is the coverage applied for in this application replacing other group insurance? ☐ Yes ☐ No

   If "Yes", give reason _____

   Plan being replaced : ☐ A ☐ B ☐ C ☐ D ☐ E ☐ HMO ☐ HMO-POS ☐ Dual Contract POS ☐ Other _____

3. Has your firm been uninsured for 3 or more months prior to application? ☐ Yes ☐ No

4. What forms of insurance are now or were in force? ☐ Health Benefits
   ☐ Prescription Drugs (attach copies of Booklet/Certificate and most recent Billing Statement)

5. Are extended benefits provided in case of termination of health benefits? ☐ Yes ☐ No

6. To the best of your knowledge are there any current or former employees or their eligible dependents whose health insurance is being continued? ☐ Yes ☐ No

Please provide the following information for each current/former employee or dependent on health continuations.

Name of Employee/Dependent	Date of Birth	Type of Continuation State/Federal/ Extended Benefits	Reason for Termination Disability/Other	Continuation Dates Start	End

If additional space is needed, attach a separate sheet, signed and dated.

7. To the best of your knowledge:
   a. Are any employees or dependents presently incapacitated? ☐ Yes ☐ No
   b. Are any dependent children incapable of self-support due to a physical or mental disability? ☐ Yes ☐ No

Additional space to explain if items 1, 2 or 3 were answered "Yes". Refer to the question number, and give details including names, where appropriate.

_____

_____

_____

_____

8. Does the employer participate in an arrangement with a Professional Employer Organization? ☐ Yes ☐ No
   (Refer to Advisory Bulletin 00-SEH-02 if you need information concerning what constitutes a Professional Employer Organization.)

SECTION IV: SIGNATURE

It is understood that, except as provided under applicable regulations, no individual shall become insured while not actively at work on a full-time basis, and only full-time employees are eligible. A full-time employee is one who regularly works at least 25 hours per week at his employer's place of business. It is further understood that no agent has the power, on behalf of Horizon Blue Cross Blue Shield of New Jersey, to make or modify any request or application for insurance or to bind Horizon BCBSNJ by making any promises or representation or by giving or receiving any information.

It is further understood that no insurance will be effective unless and until the application is accepted in writing by Horizon BCBSNJ. No contract of insurance is to be implied in any way on the basis of the completion and / or submission of this application.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

_____ _____

Print name of Officer, Partner or Proprietor Signature of Officer, Partner or Proprietor

_____ Dated at _____ on _____

Witness to Signature

Note: If there are any modifications to the statements and answers given in this application (i.e., crossed out, whited-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.

Horizon Blue Cross Blue Shield of New Jersey

NEW JERSEY SMALL EMPLOYER CERTIFICATION

Legal Name and Address of Company: _____
Name

_____
Street City State ZIP

Group Policy Number or Group Number: _____
(if a current customer)

Group Health Benefits Policy Participation

Please indicate below the number of employees by work location/State. All employees must be included, regardless of whether or not they currently have medical coverage and through whom that coverage is provided.

	Number of Employees				
Work Location (list by State)	Full-time	Part-time	Retired	COBRA or State Continuees	Other

(For Existing Small Employer Groups in the State of New Jersey OR New Applicants)

An Eligible Employee is one who works on a full-time basis with a normal work week of 25 or more hours for compensation. An employee who works less than 25 hours per week on a temporary or substitute basis, or an employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement is not an eligible employee.

Total # Eligible Employees _____

Total # Eligible Employees applying/enrolling for health benefits coverage _____

Total # Eligible Employees waiving health benefits coverage under the policy with coverage under their spouse's coverage, other than individual coverage, Medicare, Medicaid, or NJ FamilyCare or any other group Health Benefits Plan through a different employer _____

Total # Eligible Employees waiving health benefits coverage under the policy with coverage under a Health Benefits Plan issued by another carrier and offered by the small employer _____

Please separately list the name(s) of the other carrier(s) and the number of employees covered under each:

_____ _____

_____ _____

Total # Eligible employees waiving health benefits coverage under the policy without coverage under a spouse's coverage, other than individual coverage; Medicare, Medicaid, or NJ FamilyCare or any other Health Benefits Plan _____

Total # Employees in an ineligible class or classes _____

Is your firm subject to Working Aged Provisions of federal law (TEFRA/DEFRA)? ☐ Yes ☐ No
(You *may* be subject to the law if you employed 20 or more employees for 20 weeks in the current or prior calendar year)

Is your firm subject to the requirements of the federal COBRA law? ☐ Yes ☐ No
(You *may* be subject to the law if you employed 20 or more employees during 50% or more of the working days during the previous calendar year.)

CERTIFICATION AS A SMALL EMPLOYER IN THE STATE OF NEW JERSEY
IN ACCORDANCE WITH NEW JERSEY STATUTE, CHAPTER 27A OF TITLE 17B

For a policy of Group Health Benefits Insurance

(Please sign and date appropriate section indicating whether or not you meet the definition of a small employer)

"Small Employer" means, in connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership or political subdivision that is actively engaged in business that:

- Employed an average of at least two, but not more than 50, eligible Employees on business days during the preceding Calendar Year and
- Employs at least two Employees on the first day of the Plan Year, and
- The majority of the Employees are employed in New Jersey.

All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an employer that was not in existence during the preceding Calendar Year, the determination of whether the employer is a small or large employer shall be based on the average number of Employees that it is expected that the employer will employ on business days in the current Calendar Year.

☐ **I certify that I qualify as a Small Employer in the State of New Jersey.**

AND

☐ **I certify that the information provided to Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) and Horizon Healthcare of New Jersey, Inc., is true and complete.** I understand that if the above information is not complete or is not provided to Horizon BCBSNJ and Horizon Healthcare of New Jersey, Inc., in a timely manner, then health benefits coverage does not have to be offered or continued. I further understand that incomplete or untrue information may void health benefits coverage.

I understand that I and my employees may be subject to fines if an employee who is a resident of New Jersey and is eligible for coverage under this group health benefits plan is enrolled in an individual health benefits plan issued on or after August 1, 1993.

_____

Signature of Officer, Partner or Owner *Title* Date

_____

Print Name of Officer, Partner or Proprietor

_____

Signature of Witness Date

☐ **I certify that I am NOT a Small Employer in the State of New Jersey, as defined above.**

_____

Signature of Officer, Partner or Proprietor *Title* Date

_____

Print Name of Officer, Partner or Proprietor

_____

Signature of Witness Date

Any person who includes any false or misleading information on an application or enrollment form or certification for a health benefits plan is subject to criminal and civil penalties.

COMPLETE THIS SECTION ONLY IF YOU HAVE CERTIFIED THAT YOU ARE A SMALL EMPLOYER IN THE STATE OF NEW JERSEY.

***EMPLOYEE CENSUS INFORMATION**

Please include the following persons in the following list:

a. employees, owners, partners, officers and independent contractors who are actively working for the employer on a regular basis, and are paid by the employer on a regular basis, whether or not they are eligible to be covered under the policy.

b. employees, owners, partners, officers and independent contractors who are not working, but who are currently covered under the employer's health benefits plan for reasons such as continuation of coverage or total disability.

Please use the following letters to indicate Status:

F: Full-time employee who works 25 or more hours per week
P: Part-time employee who works less than 25 hours per week
T: Temporary Employee
I: Independent Contractor
D: Totally Disabled Employee
C: Continuee under state or federal law
U: Employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement.

Name	Job Title	Date of Employment	Hours Worked Per Week	Status	Work Location (State)	Gender	Date of Birth
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
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21.							
22.							
23.							
24.							
25.							
26.							
27.							
28.							
29.							
30.							

*If additional space is needed, attach a separate sheet.

Horizon

Horizon Blue Cross Blue Shield of New Jersey

SMALL EMPLOYER HEALTH BENEFITS WAIVER OF COVERAGE

Group Policy No.: _____

Policyholder Name: _____

Employee Name: _____ Social Security #: _____

Last First MI

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Date of Employment: _____ Date of Birth: _____

I was given the opportunity to enroll in this plan of group health benefits offered by my employer and insured by Horizon Blue Cross Blue Shield of New Jersey. I *refuse* the following:

☐ Employee, Spouse and Child(ren) coverage

☐ Spouse coverage

☐ Child(ren) coverage

Reason for Refusal (Please check all appropriate boxes.)

☐ Other fully insured Group Health Plan sponsored by this employer

☐ Other Group Health Plan sponsored by my spouse's employer

☐ Other group coverage sponsored by another organization

☐ Covered under Medicare

☐ Other reasons (please explain)

_____

Please identify Group Health Plan(s) and provide names(s) of Policyholder(s), carrier(s) and policy number(s).

Policyholder / Name: _____

Carrier: _____ Policy number: _____

Policyholder / Name: _____

Carrier: _____ Policy number: _____

Policyholder / Name: _____

Carrier: _____ Policy number: _____

If you are declining enrollment for yourself or your dependents (including your spouse) because of other Group Health Plan coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days after marriage, birth, adoption or placement for adoption.

If the reason for the refusal of coverage is coverage under another Group Health Plan, it is important to provide information concerning that Group Health Plan on this Waiver of Coverage form. If you fail to provide this information on this Waiver of Coverage form and you later become ineligible for such other coverage and then wish to enroll in any of the refused coverages, you will be considered a Late Enrollee and may be subject to the pre-existing conditions exclusion.

I understand that if I later wish to enroll for any of the coverage(s) refused, I will be required to submit an Enrollment Form and coverage may be subject to a pre-existing conditions exclusion.

_____ _____

Signature of Employee Date

_____ _____

Signature of Witness Date