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.