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 HMO is issued by Horizon Healthcare of New Jersey, Inc., a subsidiary of Horizon Blue Cross Blue Shield of New Jersey. Both are independent licensees of the Blue Cross and Blue Shield Association.

7215 (W0611)

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

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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.)

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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.							
12.							
13.							
14.							
15.							
16.							
17.							
18.							
19.							
20.							
21.							
22.							
23.							
24.							
25.							
26.							
27.							
28.							
29.							
30.							

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

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

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Horizon Blue Cross Blue Shield of New Jersey

You may complete the required fields below online and then save or print a copy for submission.
To save a completed copy to your computer, choose File > Save As to rename the file and save the form with your information to your computer.

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: ________ ☐ Enrollment of a new Subscriber

Date of Hire: _____/_____/_____ Effective Date/Date of Event: _____/_____/_____

Reason for Change: ________

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
☐ Spouse	____/____/____	________
☐ Civil Union Partner (CUP)/Domestic Partner (DP)	____/____/____	________
☐ Dependent Child	____/____/____	________
☐ Over-Age Child as a Dependent Under 31 *(please complete coverage continuation section)*	____/____/____	________
☐ Name Change	____/____/____	________
☐ Change Plan	____/____/____	________
☐ 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**

☐ 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: ________

Group # ________ Subgroup # ________ ***Qualifying event #s: 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 ____/____/____

Employer Address ________ City ________ Hours Worked 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

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.

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 Advantage EPO

☐ Horizon Traditional ☐ Horizon Direct Access ☐ Horizon Direct Access (HSA)

☐ Horizon POS ☐ Horizon PPO (HSA) ☐ Horizon PPO

☐ Horizon HMO ☐ Horizon HMO (HSA) ☐ Prescription ☐ 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 30 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.

SPOUSE/CUP/DP ☐ **ADD** ☐ **REMOVE** ☐ **CONTINUE SPOUSE (COBRA/NJSGC)** ☐ **CONTINUE CU PARTNER (NJSGC)** ☐ **CONTINUE DP /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 F1*

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 G*

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 G*

Submit a copy of the Certificate of Creditable Coverage

F. Preexisting Conditions – to be completed by Employee with respect to all persons to be covered who are age 19 or older. This section does not apply to any person who is under age 19.

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 who is age 19 or older 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

2. During the past 6 months, have you or any dependent to be covered who is age 19 or older:

	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?	☐	☐

G. 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 ______

H. 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: ______

I. 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: ___/___/___

J. 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: ___/___/___

K. 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 Group Information and sections A, and K in order for this application to be processed.

Employees
You must complete sections B through I and submit the signature of each Over-Age Child for which a Dependent Under 31 Continuation Election is made in accordance with Section K 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 age 26, you do not have to make a COBRA/NJSGC or Dependent Under 31 election. Instead, select “Other” in Section A, and attach proof of disability.
- 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.** 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 (NJSGC)

C4. Death of employee

C5. Loss of dependent child status (aged out) under the plan.

C6. Disability (occurring subsequent to another qualifying event)

Dependent Under 31

D1. Loss of dependent status (aged out) and otherwise eligible

D2. Re-establish eligibility: residency

D3. Re-establish eligibility: nonresident full-time student

D4. Re-establish eligibility: change in marital status

D5. Re-establish eligibility: change in parental status

D6. Re-establish 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.

Products and services provided by Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc., each of which is an independent licensee of the Blue Cross and Blue Shield Association.

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 "pre-existing 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) is age 19 or older and 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 pre-existing conditions exclusion on employees and dependents (if the plan includes coverage for dependents) age 19 or older 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
- an 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 pre-existing conditions exclusion does not apply to pregnancy. In addition, it does not apply to:

- individuals under age 19
- 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 31 Continuation

Horizon Blue Cross Blue Shield of New Jersey will bill over- age dependents directly and enrollees will remit the premium directly to Horizon BCBSNJ. When Dependent Under 31 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.

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.)

An Independent Licensee of the Blue Cross and Blue Shield Association

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