Horizon
Horizon Blue Cross Blue Shield of New Jersey

ENROLLMENT/CHANGE REQUEST

Horizon BCBSNJ

P.O. Box 1938
Newark, NJ 07101-1938
www.HorizonBlue.com/

Group Information - To Be Completed by Employer

Group Name	Group Number	Subgroup Number
Woodbridge Township BOE	086271	

A. Type of Activity - To Be Completed by Employer *Refer to instructions on back before completing this form. Print clearly.*

1. Enrollment
☐ New Subscriber
Effective Date ___/___/___
Date of Hire ___/___/___

2. Change - *Check all that apply.*

	Date of Event	Reason
☐ Add Spouse or ☐ Civil Union Partner	___/___/___	
☐ Add Dependent Child	___/___/___	
☐ Name Change	___/___/___	
☐ Change Plan	___/___/___	
☐ Other	___/___/___	
☐ Add/Change Dentist Office ID		

3. Remove or Terminate - *Check all that apply.*

	Effective Date	Reason
☐ Remove Spouse/Civil Union Partner*	___/___/___	
☐ Remove Dependent Child*	___/___/___	
☐ Employee Withdrawal/Termination	___/___/___	

Note: Employee must be enrolled for spouse/domestic partner/civil union partner/dependent(s) to have coverage.
*Please complete Add/Change/Remove and Name columns in Section D.

4. Continuation of Coverage, i.e., COBRA, State, Total Disability
Not all options are available. Contact Employer for available options.
Coverage For: ☐ Employee ☐ Dependents
Length of Continuation: ☐ 18 mos ☐ 29 mos* ☐ 36 mos ☐ Total Disability
Date of Loss of Coverage: ___/___/___
Date of Qualifying Event: ___/___/___
*Attach proof of disability

B. Employee Information - Complete Sections B - G

Social Security Number	Last Name, First Name, M.I.		Home Telephone ( )
Home Address	Apt. No.	City, State	ZIP Code
Employer Name			Work Telephone ( )
Work Address		City, State	ZIP Code
Date of Employment		Hours Worked	

C. Plan Option -

Horizon BCBSNJ	Horizon Healthcare Dental	Contract Type
____ Horizon Traditional	____ Dental Option Plan	☐ S - Single ☐ F - Family
____ Horizon PPO		☐ 2 Adults
		☐ P/C - Parent & Child

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. Attach proof if full-time college student. Attach proof of disability.

	(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex M	Sex F	Birthdate MM DD YYYY	Social Security Number	Other Coverage Check if Yes
Employee			☐	☐	/ /		☐
Spouse			☐	☐	/ /		☐
Civil Union Partner			☐	☐	/ /		☐
Child			☐	☐	/ /		☐
Child			☐	☐	/ /		☐
Child			☐	☐	/ /		☐
Child			☐	☐	/ /		☐

E. Other/Previous Insurance

Is your Spouse/Domestic Partner/Civil Union Partner Employed? ☐ Yes ☐ No If "Yes," give name & address of spouse's/Domestic Partner's/Civil Union Partner's employer.

If "Yes" to Other Coverage (Section D), give name & policy number of insurance carrier, HMO, or other source.

If "Yes" to previous coverage, identify name(s) of persons, give effective date and date coverage terminated, name of previous carrier and plan number and submit a copy of the Certificate of Credible Coverage issued by the previous carrier, if available.

F. Dependent Information

Does any dependent listed in Section D live at a different address than the Employee? ☐ Yes ☐ No If "Yes," who and at what address?

Explain the circumstances.

If any dependent's last name differs from yours, explain the circumstances.

G. Employee Signature

If you have any questions concerning the benefits and services provided by or excluded under this contract, contact a benefits representative at your company before signing this form.

I represent that all the information supplied in this enrollment/change request form is true and complete. I hereby agree to the conditions of enrollment on the reverse side of the employee copy of this enrollment/change request. I authorize deductions from my earnings for any required contribution.

Employee Signature - *Required*
X
Date ___/___/___ E-Mail Address

H. Employer Verification - To Be Completed by Employer

Employer Signature - *Required*
X
Title Date ___/___/___

Employee copy 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 BCBSNJ prior to visiting a specialist or admission to a hospital.

Services and products may be provided by Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare Dental, Inc., each of which is an independent licensee of the Blue Cross and Blue Shield Association. Horizon Healthcare Dental Inc., is a subsidiary of Horizon Blue Cross Blue Shield of New Jersey.

Instructions

Employer

- Complete the **Employer Group Information** in the upper right corner of the form.
- **Section A - Type of Activity:** Check box(es) indicating reason(s) for submitting The Enrollment Change Request Form.
  If reason is other then indicated check **other** in box 2 and provide reason (i.e., rehire, open enrollment, newly eligible or previously refused/waived coverage).
- Complete **Section H - Employer Verification** in the lower right corner of the form.
  - Employer must complete this section for all new enrollments, coverage changes and terminations.
  - Employer must sign and date The Enrollment/Change Request Form in order for it to be processed.

Employee - Complete Sections B - G

Section B - Employee Information:
Complete **all** information in order for your application to be processed.

Section C - Plan Option:
- Check one Plan Option box, indicate Plan Option Name (where applicable).
- Select only an option offered by your employer.
- Select Contract Type: **S**-Single, **F**-Family, **2**-Adults (Husband/Wife, Domestic Partner or Civil Union Partner), **P/C**-Parent & Child

Section D - Individuals Covered:
- Add/Change/Remove - Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
- If a dependent is a full-time college student, you **must** attach a current course schedule or a letter from the school confirming full-time student status (12 or more credits). If dependent is disabled and being continued beyond the limiting age, attach proof of disability.
- If you or your dependent(s) have other dental coverage, check off the "Yes" box(es) and complete Section E - Other/Previous Insurance.
- If the Plan Option selected is Horizon Dental Choice or Horizon TotalCare Dental-from the appropriate Provider directory, locate the alphanumeric office ID code for the dentist. Indicate office ID number selection(s) and NPI Number on the form. Only one provider selection allowed under the Horizon TotalCare Dental Option per family
- If you are a current patient, please check the "Current Patient" box. (only applicable if the Plan Option selected is Horizon Dental Choice or Horizon TotalCare Dental).

Section E - Other/Previous Insurance:
Complete this section for all new enrollments or coverage changes. Coverage includes group, governmental and Medicare coverages and church plans.

Section F - Dependent Information:
Complete this section for all new enrollments or coverage changes. Coverage includes group, governmental and Medicare coverages and church plans.

Section G - Employee Signature:
- Complete this section for all new enrollments, coverage changes and terminations.
- Employee must sign and date the Enrollment/Change Request Form in order for it to be processed.

Section H - Employer Verification:
- Employer must complete this section for all new enrollments, coverage changes and terminations.
- Employer must sign and date the Enrollment/Change Request Form in order for it to be processed.

Conditions of Enrollment

Employee Acknowledgements and Agreements

On behalf of myself and the dependents listed on the reverse side, I agree to or with the following:

1. a) I authorize the sources stated below to give to Horizon BCBSNJ, or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition. Authorized sources are: any physician or medical professional; any hospital, clinic or other medical care institution; any carrier; any consumer reporting agency; any employer.

   b) I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which Horizon BCBSNJ has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.

   c) I know that I have a right to receive a copy of this authorization if I request one.

   d) I agree that a photocopy of this authorization is as valid as the original.
2. I acknowledge by enrolling in a Horizon BCBSNJ dental program, coverage is provided by Horizon BCBSNJ in accordance with the contract.
3. Enrollment of myself and of the listed dependents into the plan is effective on acceptance by Horizon BCBSNJ.
4. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. My employer is hereby authorized to withhold payments from my wages, as appropriate.

Misrepresentation

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