



APPLICATION/CHANGE REQUEST

Horizon Blue Cross Blue Shield of New Jersey

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

Horizon Blue Cross Blue Shield of New Jersey

A. Type of Activity

1. Enrollment

New Subscriber

YES NO

Requested Effective Date

MM	DD	YYYY
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Please refer to instructions on back before completing this form. Please Print Clearly

2. Change - Check all that apply.

	Date of Event	Reason		Date of Event	Reason
<input type="checkbox"/> Add Spouse/Domestic Partner	___/___/___	_____	<input type="checkbox"/> Change Plan	___/___/___	_____
<input type="checkbox"/> Add Dependent Child	___/___/___	_____	<input type="checkbox"/> Other	___/___/___	_____
<input type="checkbox"/> Name Change	___/___/___	_____	<input type="checkbox"/> Add/Change Office ID Numbers: Primary Care Physician		

3. Remove or Terminate - Check all that apply.

	Date of Event	Reason		Date of Event	Reason
<input type="checkbox"/> Remove Applicant*	___/___/___	_____	<input type="checkbox"/> Remove Dependent Child*	___/___/___	_____
<input type="checkbox"/> Remove Spouse	___/___/___	_____	*Please complete Add/Change/Remove and Name areas in Section C		
<input type="checkbox"/> Remove Domestic Partner	___/___/___	_____			

B. Applicant Information - Complete Sections B-H

Applicant

(A)dd (C)hange (R)emove

Last Name: _____ MI: _____

First Name: _____ MI: _____

Sex: M F

Social Security #: _____

Date of Birth: MM DD YYYY

Primary Care Physician #: _____

Current Patient: YES NO

Previous Coverage: YES NO

Home Address: _____ APT: _____

City: _____ State: _____ Zip Code: _____

Primary Residence: _____ APT: _____

City: _____ State: _____ Zip Code: _____

Home Telephone #: _____ Work Telephone #: _____

Are you a Resident of the State of New Jersey? YES NO

Do you maintain a residence in any other state? YES NO

If "Yes" name of state _____ How much time do you spend there each year? _____

C. Individuals Covered - List individuals for whom you are adding/changing/removing coverage.

Attach sheet to list additional children. Attach proof if Full-Time Post-Secondary (*FTPSS) Student.

Spouse Domestic Partner

(A)dd (C)hange (R)emove

Last Name: _____ MI: _____

First Name: _____ MI: _____

Sex: M F

Social Security #: _____

Date of Birth: MM DD YYYY

Primary Care Physician #: _____

Current Patient: YES NO

Previous Coverage: YES NO

Child

(A)dd (C)hange (R)emove

Last Name: _____ MI: _____

First Name: _____ MI: _____

Sex: M F

*FTPSS: YES NO

Social Security #: _____

Date of Birth: MM DD YYYY

Primary Care Physician #: _____

Current Patient: YES NO

Previous Coverage: YES NO

Child

(A)dd (C)hange (R)emove

Last Name: _____ MI: _____

First Name: _____ MI: _____

Sex: M F

*FTPSS: YES NO

Social Security #: _____

Date of Birth: MM DD YYYY

Primary Care Physician #: _____

Current Patient: YES NO

Previous Coverage: YES NO

G. Dependent Information

Does any dependent listed in Section C live at a different address than the Applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," identify the individual(s) and at what address?
Explain the circumstances.
If any dependent's last name differs from yours, explain the circumstances.

H. Availability of Coverage

Are you or any person named on this application eligible for coverage under a group or governmental plan, a church plan, Medicare, Medicaid or any successor program? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," identify the individual(s), give name of carrier, policy number and identify coverage type.
Are you or any person named on this application covered under a group or governmental plan, a church plan or Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," identify the individual(s), give name of carrier, policy number and identify coverage type.
Was previous coverage, if any, terminated because a person covered under the plan committed fraud or for failure to pay premiums? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," identify the individual(s), and briefly describe the circumstances.
Were any of the individual's to be covered under an individual plan given the opportunity to continue previous coverage, if any, under COBRA or a similar state continuation law? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," did the individual(s) remain covered for the entire period that continuation was available to him or her? <input type="checkbox"/> Yes <input type="checkbox"/> No Identify any person who did not continue for entire period available.
Were any of the individual's to be covered under an individual plan, as of the date of this application, continuously covered under a previous plan or plans for a period of 18 or more months without a break in coverage of 63 or more days? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," identify the individual(s).
Were any of the individual's most recent prior creditable coverage under a group health plan, governmental plan, church plan, or health insurance coverage offered in connection with any such plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," identify the individual(s).

Please include a Certificate of Creditable Coverage, if available.

I. Payment Information

<input type="checkbox"/> Monthly
Payment Instrument <input type="checkbox"/> Automatic Bank Draft (attach Voided check) <input type="checkbox"/> Check <input type="checkbox"/> Money Order
<input type="checkbox"/> Credit Card-Type _____ Card No. _____ Exp. Date _____
Name on card _____

J. Applicant Signature

If you have any questions concerning the benefits and services provided by or excluded under this Policy please contact your Broker or a Horizon Blue Cross Blue Shield of New Jersey Sales Representative at 800-224-1234, before signing this form.

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the reverse side of this application/change request.
Applicant Signature - Required X _____ Date ___ / ___ / ___ E-Mail Address _____

K. Broker/General Agent Information

Signature Preparer: _____ Date ___ / ___ / ___
NJ Producer License #: _____
Broker/General Agent: _____
Agent/Vendor # _____

Eligibility Requirements

1. Eligibility requirements are determined under the Individual Health Coverage Reform Act of 1992, P.L. 1992, c.161.
2. You must be a New Jersey resident.
3. You and any family members you wish to cover must not be eligible to be covered under:
(a) a group Health Benefits Plan, Group Health Plan, Government Plan, or Church Plan, or (b) Medicare. (See Eligibility Requirements item 5 below.)
4. 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 the other plan is being replaced by the plan being applied for with this application.
5. If the requested effective date is not completed, your effective date shall be no later than the first of the month following the month in which the completed application was dated and premium payment are received by us or our duly authorized agent. However, with respect to applications submitted during the October Open Enrollment Period by persons who are eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan, or persons who wish to replace their current health benefits plan with a more comprehensive individual health benefits plan, the effective date of coverage shall be January 1 of the following calendar year. Current coverage should not be terminated until new coverage is in effect.

Applicant copy may be used as a temporary ID card for 30 days from the effective date if authorized by Horizon BCBSNJ or Horizon Healthcare of New Jersey, Inc. Coverage must be verified with Horizon BCBSNJ or Horizon Healthcare of New Jersey, Inc. 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 of New Jersey, Inc., each of which is an independent licensee of the Blue Cross and Blue Shield Association.



Horizon Blue Cross Blue Shield of New Jersey

INSTRUCTIONS

Section A - Type of Activity:

Provide all information that applies to the reason you are completing this application/change form.

Section B - Applicant Information:

Complete **all** information in order for your application to be processed.

Section C - 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 post-secondary student, you **must** attach a current course schedule or a letter from the school or it's authorized representative confirming full-time student status.
If dependent is disabled and being continued beyond the limiting age, attach proof of disability.
- From the appropriate provider directory, locate the alphanumeric number for the primary care physician. Indicate office ID number selection(s) on the form.
- Your Primary Care Office ID Number is the J or K code located in your benefit booklet.
- Please mark **Yes** or **No** in the "Current Patient" box.
- Please mark **Yes** or **No** in the "Previous Coverage" box.

Section D - Plan Option:

- Check type of contract.
- Check one Plan Option box, and check one Copay and/or Deductible Amount (if applicable).

Section E - Pre-Existing Conditions Statement:

Complete this section for all new enrollments.

Section F - Previous Insurance:

Complete this section for all new enrollments or coverage changes. Coverage includes individual or group coverage, governmental coverage, a church plan or Medicare or Medicaid including NJ FamilyCare.

Section G - Dependent Information:

Complete this section for all new enrollments or coverage changes.

Section J - Applicant Signature:

- Applicant must sign and date the Application/Change Request Form in order for it to be processed.
- Complete this section for all new enrollments, coverage changes and terminations.

Conditions of Enrollment Applicant Acknowledgements and Agreements

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

1. a) I authorize the sources stated below to give to Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc. 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 Blue Cross Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc. 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 Blue Cross Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc. individual policy, coverage is provided by Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc. in accordance with the contract.
3. Enrollment of myself and of the listed dependents into the plan is effective on acceptance by Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc.
4. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the policy.

Misrepresentation

5. Any person who includes any false or misleading information on an Application/Change Request Form for a health benefits plan is subject to criminal and civil penalties.