



ENROLLMENT/CHANGE REQUEST

Horizon Blue Cross Blue Shield of New Jersey

Attn: Small Group Enrollment
Horizon Blue Cross Blue Shield of NJ
PO Box 607, Dept. A
Newark, NJ 07101-0607
www.horizonblue.com

Horizon Blue Cross Blue Shield of New Jersey

Group Information - To Be Completed by Employer

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

1. Enrollment <input type="checkbox"/> New Subscriber Effective Date ___/___/___ Date of Hire ___/___/___	2. Change - Check all that apply. <table border="1"> <tr> <td><input type="checkbox"/> Add Spouse/Domestic Partner</td> <td>___/___/___</td> <td>Reason</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Add Dependent Child</td> <td>___/___/___</td> <td>Reason</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Name Change</td> <td>___/___/___</td> <td>Reason</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Change Plan</td> <td>___/___/___</td> <td>Reason</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Other</td> <td>___/___/___</td> <td>Reason</td> <td>_____</td> </tr> <tr> <td colspan="4"><input type="checkbox"/> Add/Change Office ID Numbers: Primary Care Physician/Ob/Gyn</td> </tr> </table>	<input type="checkbox"/> Add Spouse/Domestic Partner	___/___/___	Reason	_____	<input type="checkbox"/> Add Dependent Child	___/___/___	Reason	_____	<input type="checkbox"/> Name Change	___/___/___	Reason	_____	<input type="checkbox"/> Change Plan	___/___/___	Reason	_____	<input type="checkbox"/> Other	___/___/___	Reason	_____	<input type="checkbox"/> Add/Change Office ID Numbers: Primary Care Physician/Ob/Gyn				3. Remove or Terminate - Check all that apply. <table border="1"> <tr> <td><input type="checkbox"/> Remove Spouse/Domestic Partner*</td> <td>___/___/___</td> <td>Effective Date</td> <td>___/___/___</td> <td>Reason</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Remove Dependent Child*</td> <td>___/___/___</td> <td>Effective Date</td> <td>___/___/___</td> <td>Reason</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Employee Withdrawal/Termination</td> <td>___/___/___</td> <td>Effective Date</td> <td>___/___/___</td> <td>Reason</td> <td>_____</td> </tr> </table> <p>NOTE: Employee must be enrolled for spouse/dependent(s) to have coverage. *Please complete Add/Change/Remove and Name columns in Section D.</p>	<input type="checkbox"/> Remove Spouse/Domestic Partner*	___/___/___	Effective Date	___/___/___	Reason	_____	<input type="checkbox"/> Remove Dependent Child*	___/___/___	Effective Date	___/___/___	Reason	_____	<input type="checkbox"/> Employee Withdrawal/Termination	___/___/___	Effective Date	___/___/___	Reason	_____	4. Continuation of Coverage, i.e., COBRA, State, total disability <small>Not all options are available. Contact Employer for available options.</small> Coverage For: <input type="checkbox"/> Employee <input type="checkbox"/> Dependents Length of Continuation: <input type="checkbox"/> 12 mos <input type="checkbox"/> 18 mos <input type="checkbox"/> 29 mos <input type="checkbox"/> 36 mos <input type="checkbox"/> Total Disability* Date of Loss of Coverage: ___/___/___ Date of Qualifying Event: ___/___/___ <small>*Attach proof of total disability</small>
<input type="checkbox"/> Add Spouse/Domestic Partner	___/___/___	Reason	_____																																										
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B. Employee Information - Complete Sections B - H

Social Security Number	Last Name, First Name, M.I.		Home Telephone ()	
Home Address	Apt.	City, State	ZIP Code	
Employer Name			Work Telephone ()	
Work Address	City, State		ZIP Code	
Date of employment ___/___/___ Hours worked per week _____				

C. Plan Option - Your selection must be offered by your employer.

Medical Check One: S F H/W (or DP) P/C
Dental Check One: S F H/W (or DP) P/C
Prescription Check One: S F H/W (or DP) P/C

 Horizon Traditional Horizon HMO
 Horizon POS Horizon PPO
 Horizon Direct Access Prescription
 Other _____

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.

	(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex M F	Birthdate MM DD YYYY	Social Security Number	Other Health Coverage	Primary Care Office ID Number	Current Patient	Previous Coverage
Employee			<input type="checkbox"/> <input type="checkbox"/>	/ /		Yes <input type="checkbox"/>		Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Spouse			<input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Domestic Partner			<input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Child			<input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Child			<input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Child			<input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

E. Pre-Existing Conditions Statement

NOTE: 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 can only use the information to expedite the processing of claims.

Yes No

1. During the past 6 months have you or any dependent to be covered had or been diagnosed as having any of the following? If "Yes," check appropriate box(es) below.

<input type="checkbox"/> a. Alcoholism or Drug Abuse	<input type="checkbox"/> h. Heart Disorder or Condition
<input type="checkbox"/> b. Arthritis	<input type="checkbox"/> i. High Blood Pressure
<input type="checkbox"/> c. Blood Disorder	<input type="checkbox"/> j. Kidney or Liver Disorder
<input type="checkbox"/> d. Back or Neck Disorder, Injury or Pain	<input type="checkbox"/> k. Lung or Respiratory Disorder
<input type="checkbox"/> e. Cancer or Tumors	<input type="checkbox"/> l. Mental or Nervous Disorder
<input type="checkbox"/> f. Diabetes	<input type="checkbox"/> m. Paralysis, Stroke or Epilepsy
<input type="checkbox"/> g. Gastro or Intestinal Disorder	

Yes No

2. During the past 6 months, have you or any dependent to be covered:

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 medications?

Please give details for "Yes" answers to any part of Questions 1 or 2 on a separate sheet of paper. This separate sheet should be signed and dated.

F. Other/Previous Insurance

Is your spouse or domestic partner employed? Yes No If "Yes," give name & address of spouse's or domestic partner's employer.

If "Yes" to Other Health Coverage (Section D.) give name and policy number of insurance carrier, HMO or other source. If enrolled in Medicare Parts A and/or B, identify the coverage and provide the Medicare ID number.

If "Yes" to Previous Coverage, identify name(s) of persons, give effective date and date coverage terminated, name of previous carrier and plan number.

G. Dependent Information

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

Explain the circumstances.

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

H. Employee Signature

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

I represent that all information supplied in this application 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 contributions.

Employee Signature - Required

X

Date ___/___/___ E-Mail Address _____

I. Employer Verification - To Be Completed by Employer

Employer Signature - Required

X

Title _____ Date ___/___/___