Horizon Blue Cross Blue Shield of New Jersey

APPLICATION FOR A SMALL EMPLOYER DENTAL BENEFITS POLICY

Horizon Blue Cross Blue Shield
of New Jersey
Dental Programs
3 Penn Plaza East PP-03K
Newark, NJ 07105-2200
1-800-4-DENTAL

Please print or type ☐ New Policy ☐ Change in Policy Policy No. ____________ Requested Effective Date ____________

SECTION I: POLICYHOLDER INFORMATION

1. Policyholder (full legal name of company): ____________
2. Tax Identification Number: ☐☐☐☐☐☐☐☐☐ e-mail Address: ____________
3. Main Address: ____________ (STREET, CITY, STATE, ZIP CODE, COUNTY)

   Mailing Address (Billing): ____________

   Telephone: ☐☐☐-☐☐☐-☐☐☐☐ Facsimile: ☐☐☐-☐☐☐-☐☐☐☐
4. Name of Company Official: ____________ 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: ____________ *(Eligible employees are those who work at least 25 hrs. per week)*
8. Number of eligible employees to be insured: ____________
9. Class or classes to be excluded: ____________
10. Insurance requested for: ☐ Employees Only ☐ Employees and Dependents (daughter/son/spouse/domestic partner)
11. Are you subject to the requirements of COBRA? ☐ Yes ☐ No
12. Waiting period before new/rehired employees become insured: (may not exceed 6 months) Present: ____________ New: ____________
13. What percentage of the premium will the employer pay? ____________
14. Deposit $ ____________

Premium Paid: ☐ Monthly ☐ Quarterly ☐ Automatic checking withdrawal

The premium for the first month of coverage must be attached.

Premium will be due as of the effective date.

SECTION II: SPECIFICATIONS FOR COVERAGE *(Dental Benefits Selection)*

1. ☐ Horizon Dental Option Plan (Traditional)
2. ☐ Horizon Dental PPO Plan
3. ☐ Horizon Basic Dental Companion Plan
4. ☐ Horizon Dental Companion Plan
5. ☐ Horizon Dental Choice

SECTION III: ALL QUESTIONS MUST BE ANSWERED

a. 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 ____________

   Please attach copy of the prior carrier bill received in last 90 days.

b. Has your firm been uninsured for 3 or more months prior to application? ☐ Yes ☐ No

SECTION IV: SIGNATURE

It is understood that 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 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 Healthcare Dental Services on behalf of Horizon Blue Cross Blue Shield of New Jersey by making any promise 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 Blue Cross Blue Shield of New Jersey. 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 knowingly files a statement of claim, application for insurance, enrollment form, or certification containing any false or misleading information may be subject to criminal and civil penalties.

____________ Print name of Officer, Partner, or Owner

____________ Signature of Officer, Partner, or Owner

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.

An Independent Licensee of the Blue Cross and Blue Shield Association

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 GROUP DENTAL ENROLLMENT USE	
Coverage Code c/o	
TOTAL APPLICATIONS SUBMITTED	
TRANSFER FROM GROUP # ______________________	
REFUSALS/WAIVERS LISTING ATTACHED (IF APPLICABLE)	
EMPLOYER CONTRIBUTION	
EFFECTIVE DATE	
FUTURE RATE RENEWAL DATE	

	SALES ASSOCIATE SIGNATURE	DATE	ITEM NUMBER
APPROVED BY:	SALES ADMINISTRATION SIGNATURE	TITLE	DATE