Waiving Insurance/Change Insurance

Horizon
Horizon Blue Cross Blue Shield of New Jersey

ENROLLMENT/CHANGE REQUEST
Horizon BCBSNJ Dental Programs

P.O. Box 1938
Newark, NJ 07101-1938
www.horizonblue.com/dental
1-800-4DENTAL

Group Information - To Be Completed by Employer

Group Name	Group Number	Subgroup Number
Hammonton BOE	098185	000

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 07 / 01 / 2017
Date of Hire ___/___/___

2. Change - *Check all that apply.*

	Date of Event	Reason
☐ Add Spouse/Domestic 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/Domestic Partner*	___/___/___	
☐ Remove Dependent Child*	___/___/___	
☐ Employee Withdrawal/Termination	___/___/___	

Note: Employee must be enrolled for spouse/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: ☐ 12 mos ☐ 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 - Your selection must be offered by your employer.

Horizon BCBSNJ	Horizon Healthcare Dental	Contract Type
☐ Horizon Dental Option	☐ *Horizon Dental Choice	☐ S - Single ☐ F - Family
☐ Horizon Dental PPO	☐ *Horizon TotalCare Dental	☐ H/W - Husband & Wife (or Domestic Partners)
☐ Horizon Dental PPO Access		☐ P/C - Parent & Child

*Please select Dentist Office ID Number-Section D

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 F	Birthdate MM DD YYYY	Social Security Number	Other Dental Coverage Check if Yes	Dentist Office ID Number (if applicable)	Current Patient Check if Yes	Previous Coverage Check if Yes
Employee			☐ ☐	/ /		☐		☐	☐
Spouse			☐ ☐	/ /		☐		☐	☐
Domestic Partner*			☐ ☐	/ /		☐		☐	☐
Child			☐ ☐	/ /		☐		☐	☐
Child			☐ ☐	/ /		☐		☐	☐
Child			☐ ☐	/ /		☐		☐	☐

*Please attach proof of Domestic Partnership

E. Other/Previous Insurance

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

If "Yes" to Other Dental 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.

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 Donna Davison

Title: Secretary

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 Dental Programs prior to visiting a specialist or admission to a hospital.