Horizon.

Horizon Blue Cross Blue Shield of New Jersey

GROUP ENROLLMENT/CHANGE REQUEST

Mail to: Horizon BCBSNJ
Attn: Large and Mid-Size Group Enrollment
P.O. Box 10168
Newark, NJ 07101-3168
Email to: Midmajor_enrollment@horizonblue.com
Fax to: (973) 274-2297
HorizonBlue.com

Group Information – to be completed by Employer.

Group Name: Hammonton BOE Group Number: 8511J

Sub Group Number: _____ Date of Hire: ____/____/____ Effective Date/Date of Event: ____/____/____

Reason: _____

A. Type of Activity – to be completed by Employer.

Refer to instructions before completing this form. Print clearly.

☐ ADD ☐ REMOVE ☐ OTHER CHANGE	Effective Date	Reason for Change
☐ Subscriber	____/____/____	
☐ Spouse	____/____/____	
☐ Civil Union Partner (CUP)	____/____/____	
☐ Domestic Partner (DP)	____/____/____	
☐ Dependent Child	____/____/____	
☐ Over-Age Child as a Dependent Under 31 *(and complete Coverage Continuation section)*	____/____/____	
☐ Name Change	____/____/____	
☐ Change Plan	____/____/____	
☐ Other	____/____/____	
☐ Add/Change Office ID Numbers: Primary Care Provider	____/____/____	

COVERAGE CONTINUATION

☐ **For Employee** Billing: ☒ Group

Date of Loss of Coverage ____/____/____ Qualifying Event #** _____ Date of Qualifying Event ____/____/____

☐ Total Disability* ☐ COBRA/NJSGC Length of Continuation (in months): ☐ 18 ☐ 29 **Attach proof of disability*

☐ **For Spouse/Civil Union Partner*/Domestic Partner** Billing: ☒ Group

Date of Loss of Coverage ____/____/____ Qualifying Event #** _____ Date of Qualifying Event ____/____/____

☐ COBRA/NJSGC Length of Continuation (in months): ☐ 18 ☐ 29 ☐ 36

**Civil union partners are eligible to make an election pursuant to NJSGC, if applicable.*

☐ **For Dependent or Over-aged Child**

☐ COBRA/NJSGC Length of Continuation (in months): ☐ 18 ☐ 29 ☐ 36 Billing: ☒ Group

Date of Loss of Coverage ____/____/____ Qualifying Event #** _____ Date of Qualifying Event ____/____/____

☐ Dependent Under 31 Billing: ☒ Home

Date of Loss of Coverage ____/____/____ Qualifying Event #** _____ Date of Qualifying Even ____/____/____

Home Address: _____

***Qualifying event #s: see list in Instructions.*

B. Employee Information – to be completed by Employee.

☐ ADD ☐ REMOVE ☐ CONTINUATION ☐ OTHER CHANGE

If a name change, indicate prior name: _____

Last Name, First Name, M.I. _____

Social Security # _____ Date of Birth ____/____/____ Sex _____

Home Address _____ Apt. ____ City _____ State _____ Zip Code _____

Home Phone _____ E-Mail Address _____

Employer Name Hammonton BOE Employment Date ____/____/____

Employer Address 556 Old Fork Road City Hammonton State NJ Zip Code 08037

Hours Worked Per Week _____ Work Phone _____ E-Mail Address _____

Primary Care Provider Name _____ Current Patient ☐ Yes ☐ No

NPI # _____ Loc Code _____

Other Health Coverage ☐ Yes ☐ No, If Yes, Payer Name _____

Policy # _____ Medicare ID #, If any _____

The Employee Copy of this application may be used as a temporary ID card for thirty days from the effective date if authorized by Employer. Coverage must be verified with Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc. prior to visiting a physician or admission to a hospital.

C. Race/Ethnicity – to be completed by the Employee, at his/her option.

NOTE: Your response is appreciated but NOT required! *Choose a category that most closely describes you:*

☐ American Indian or Alaskan Native ☐ Black, not of Hispanic origin
☐ Hispanic ☐ Asian or Pacific Islander ☐ White, not of Hispanic origin

D. Plan Option – to be completed by the Employee. Your selection must be offered by your employer.

Medical *Check One:* ☐ S ☐ F ☐ 2 Adults ☐ PC

☐ Horizon Traditional
☐ Horizon HMO
☐ Horizon POS
☐ Horizon PPO
☑ Horizon Direct Access
☐ Horizon PPO (HRA)
☐ Horizon PPO (HSA)
☐ OMNIA
☐ Horizon Direct Access (HRA)
☐ Horizon Direct Access (HSA)
☐ Horizon (EPO)
☐ OMNIA (HSA)
☐ Horizon Advantage (EPO)
☐ Horizon Advantage EPO (HRA)
☐ Horizon Advantage EPO (HSA)

Dental *Check One:* ☐ S ☐ F ☐ 2 Adults ☐ PC

☐ Horizon Dental Option Plan
☐ Horizon Healthy Smiles
☐ Horizon Dental PPO Plan
☐ Horizon Healthy Smiles Plus
☐ Horizon Dental PPO Access

Vision *Check One:* ☐ S ☐ F ☐ 2 Adults ☐ PC

☐ Horizon Expanse V
☐ Horizon Expanse VI
☐ Horizon Expanse VII-A
☐ Horizon Expanse VII-B
☐ Horizon Expanse VIII
☐ Horizon Expanse IV
☐ Horizon Panorama III - ALT. A
☐ Horizon Panorama III - ALT. B
☐ Horizon Panorama IV - ALT. A
☐ Horizon Panorama III - ALT. B
☐ Horizon Vista I
☐ Horizon Vista II
☐ Horizon Vista III
☐ Horizon Vista IV

Prescription *Check One:* ☐ S ☐ F ☐ 2 Adults ☐ PC

S = Single; F = Family; 2 Adults = Husband/Wife, Civil Union Partners or Domestic Partners; P/C = Parent/Child(ren)

E. Other Individuals Covered – to be completed by Employee.

Identify individuals other than yourself for whom you are adding/changing/removing/continuing coverage. Attach additional pages if necessary, with your signature and dated. Attach proof of disability.

1. SPOUSE/CUP/DP ☐ **ADD** ☐ **REMOVE** ☐ **CONTINUE SPOUSE (COBRA/NJSGC)**
☐ **CONTINUE CU PARTNER (NJSGC)** ☐ **CONTINUE DP (COBRA/NJSGC)** ☐ **OTHER CHANGE**

Last Name, First Name, M.I. _____

Social Security # _____ Date of Birth ____/____/____ Sex _____

Primary Care Provider Name _____ Current Patient ☐ Yes ☐ No

NPI # _____ Loc Code _____

Other Health Coverage ☐ Yes ☐ No, If Yes, Payer Name _____

Policy # _____ Medicare ID #, If any _____

Home or billing address same as Employee? ☐ Yes ☐ No *If No, Complete Section F2*

2. Child ☐ **ADD** ☐ **REMOVE** ☐ **CONTINUATION** ☐ **OTHER CHANGE**

Last Name, First Name, M.I. _____

Social Security # _____ Date of Birth ____/____/____ Sex _____

Primary Care Provider Name _____ Current Patient ☐ Yes ☐ No

NPI # _____ Loc Code _____

Other Health Coverage ☐ Yes ☐ No, If Yes, Payer Name _____

Policy # _____ Medicare ID #, If any _____

If last name is different from Employee's, please explain: _____

Living with Employee? ☐ Yes ☐ No *If No, Complete Section G*

3. Child ☐ **ADD** ☐ **REMOVE** ☐ **CONTINUATION** ☐ **OTHER CHANGE**

Last Name, First Name, M.I. _____

Social Security # _____ Date of Birth ____/____/____ Sex _____

Primary Care Provider Name _____ Current Patient ☐ Yes ☐ No

NPI # _____ Loc Code _____

Other Health Coverage ☐ Yes ☐ No, If Yes, Payer Name _____

Policy # _____ Medicare ID #, If any _____

If last name is different from Employee's, please explain: _____

Living with Employee? ☐ Yes ☐ No *If No, Complete Section G*

F. Additional Spouse/CUP/DP Information – to be completed by Employee. *If not applicable mark as N/A.*

1. Employer Name _____ Employer Phone _____

   Employer Address _____

   City _____ State _____ Zip Code _____

2a. Home Address _____ Apt _____

   City _____ State _____ Zip Code _____

2b. Please explain why the address is different: _____

G. Additional Child Information – to be completed by Employee.

Provide information below about children listed in Section E, if they have a different address from the employee. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.

Name _____

Address _____ Apt _____

City _____ State _____ Zip Code _____

Reason: _____

Name _____

Address _____ Apt _____

City _____ State _____ Zip Code _____

Reason: _____

H. Employee Signature

I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I authorize deductions from my earnings for any contributions required from me.

Signature: _____ Date: ____/____/____

I. Over-Age Child's Signature

I represent that all the information supplied in this application regarding the Dependent Under 31 Continuation Election is true and complete.
I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form.
I hereby agree to make premium payments required from me for the Dependent Under 31 Continuation Election.

Signature: _____ Date: ____/____/____

J. Employer Verification

The requested activity is believed eligible and is approved by the Employer.

Employer Representative: _____ Date: ____/____/____

Representative's Title: _____

Horizon BlueCross BlueShield 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 Board of Ed	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
__/__/1__
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 Dana Dawn

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.

BeneCard PBF
Prescription Benefit Facilitator

ENROLLMENT FORM

TODAY'S DATE:

CLIENT INFORMATION

nmonton Board of Education

NT NAME (PLAN SPONSOR / EMPLOYER) | CLIENT # | GROUP #

CARDMEMBER INFORMATION

T NAME | MI | LAST NAME | ID # | SSN#

ING ADDRESS | CITY | STATE | ZIP CODE

NE NUMBER | CELL PHONE | EMAIL

COVERAGE TYPE

SE CHECK ONE:
SINGLE ☐ CARDMEMBER/SPOUSE ☐ CARDMEMBER/CHILD ☐ CARDMEMBER/CHILDREN ☐ FAMILY

EFFECTIVE DATE:

REASON CODE

	NEW ENROLLMENT
	REINSTATE MEMBER
	REINSTATE DEPENDENT / SPOUSE
	ADD DEPENDENT / SPOUSE
	TERMINATE COVERAGE
	TERMINATE DEPENDENT COVERAGE
	NAME CHANGE
	ADDRESS CHANGE
	GROUP CHANGE: FROM_____ TO_____

J	RDS ENROLLMENT, APPLICATION NUMBER IF APPLICABLE: _____
K	ISSUE CARD
L	DO NOT ISSUE ID CARD
M	COBRA ENROLLMENT
N	COBRA TERMINATION
O	STUDENT STATUS UPDATE
P	DISABLED DEPENDENT
Q	OVERAGE DEPENDENT**
R	DEPENDENT ADDRESS DIFFERS FROM CARDMEMBER (INCLUDE ON BACK)

ELIGIBILITY

	LAST NAME	FIRST NAME	MI	GENDER	BIRTHDATE	SSN	HICN	REASON CODES
DMEMBER								
POUSE								
AIL/PHONE*								
EPENDENT								
AIL/PHONE*								
EPENDENT								
AIL/PHONE*								
EPENDENT								
AIL/PHONE*								
EPENDENT								
AIL/PHONE*								
EPENDENT								
AIL/PHONE*								
EPENDENT								
AIL/PHONE*								

AIL ONLY IF DIFFERENT FROM CARMEMBER

COORDINATION OF BENEFITS

DARY COVERAGE ID NUMBER | INSURANCE COMPANY | POLICY / GROUP#

YER/PLAN SPONSOR | EFFECTIVE DATE

SIGNATURES

R SIGNATURE | CLIENT SIGNATURE

FOR INTERNAL USE ONLY:
DATE ENTERED:_____ ENTERED BY:_____ LOGGED BY:_____

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