



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

New Subscriber

Requested Effective Date

YES NO

MM DD YYYY

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

1. Enrollment

2. Change - Check all that apply.

<input type="checkbox"/> Add Spouse/Domestic Partner	Date of Event	Reason	<input type="checkbox"/> Change Plan	Date of Event	Reason
<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.

<input type="checkbox"/> Remove Applicant*	Date of Event	Reason	<input type="checkbox"/> Remove Dependent Child*	Date of Event	Reason
<input type="checkbox"/> Remove Spouse	____/____/____	_____		____/____/____	_____
<input type="checkbox"/> Remove Domestic Partner	____/____/____	_____			

*Please complete Add/Change/Remove and Name areas in Section C

B. Applicant Information - Complete Sections B-H

Applicant

(A)dd (C)hange (R)emove Last Name First Name MI

Sex Social Security # Date of Birth Primary Care Physician # Current Patient Previous Coverage

M F MM DD YYYY YES NO 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 First Name MI

Sex Social Security # Date of Birth Primary Care Physician # Current Patient Previous Coverage

M F MM DD YYYY YES NO YES NO

Child

(A)dd (C)hange (R)emove Last Name First Name MI

Sex *FTPSS Social Security # Date of Birth Primary Care Physician # Current Patient Previous Coverage

M F YES NO MM DD YYYY YES NO YES NO

Child

(A)dd (C)hange (R)emove Last Name First Name MI

Sex *FTPSS Social Security # Date of Birth Primary Care Physician # Current Patient Previous Coverage

M F YES NO MM DD YYYY YES NO YES NO

G. Dependent Information

Does any dependent listed in Section C live at a different address than the Applicant? Yes 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? Yes 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? Yes 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? Yes 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? Yes No If "Yes," did the individual(s) remain covered for the entire period that continuation was available to him or her? Yes 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? Yes 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? Yes No If "Yes," identify the individual(s).

Please include a Certificate of Creditable Coverage, if available.

I. Race/Ethnicity (* RESPONDING TO THIS QUESTION IS OPTIONAL AND NOT REQUIRED)

Choose a category that most closely describes you:

a. American Indian or Alaskan Native b. Asian or Pacific Islander c. Black, not of Hispanic origin d. Hispanic e. White, not of Hispanic origin

J. Payment Information

Monthly

Payment Instrument Automatic Bank Draft (attach Voided check) Check Money Order

Credit Card-Type _____ Card No. _____ Exp. Date _____

Name on card _____

K. 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 _____

L. Broker/General Agent Information

Signature Preparer: _____ Date ___/___/___

NJ Producer License #: **8750393**

Broker/General Agent: **X-EII Employee Benefits**

Agent/Vendor # **0000-85**

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 November 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

RETURN APP.

To :

134 FAIRFIELD RD.
FAIRFIELD NJ
07004

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 I - Race/Ethnicity:

*Responding to this question is optional and NOT required. Complete this section for all new enrollments.

Section K - 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.