Horizon Blue Cross Blue Shield of New Jersey

Small Employer Dental Group Application Instructions

Instructions

The attached form should be completed with the assistance of your authorized Broker.

Please complete all necessary forms in their entirety. Please print in ink or type your responses. Ensure that all areas requiring a **signature and date are complete.**

Completed enrollment application forms should be sent to your authorized Broker prior to your effective date.

Application

Attached you will find the Application for a Small Employer Dental Benefits Policy that must be completed and submitted for each New Jersey small employer group applying for dental coverage.

Other Required Documents

When submitting your paperwork as required above, you must submit the following:

- Enrollment Change / Request Form (#6803) – One form is needed for each employee enrolling. Your authorized Broker will provide these forms.
- First month's premium – All new cases must be submitted with a company check for the first check, the case will be returned.

If you select the automatic checking withdrawal option, you must also submit an Automatic Pay Plan Application (#8977).

Horizon Healthy Smiles

For the Horizon Healthy Smiles plans there is a 6 month waiting period for basic restorative services and a 12 month waiting period for onlays and crowns, endodontics, periodontics and prosthodontics. To waive the waiting periods, you must provide the name of your dental carrier and the dental group number of your creditable dental coverage that is active on the day you submit your application. Creditable dental coverage is a dental plan that provides full dental coverage. It does not include a pediatric dental plan that only provides benefits for members under age 19, a dental discount plan or a preventive only dental plan.

Mailing Instructions

Please send the completed paperwork and attachments to:

Horizon Blue Cross Blue Shield of New Jersey
Three Penn Plaza East PP-13T
Newark, NJ 07105-2200

Horizon
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-13T
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): _____
   STREET CITY STATE ZIP CODE COUNTY
   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: _____ 8. Number of eligible employees to be insured: _____
   (Eligible employees are those who work at least 25 hrs. per week)
9. Class or classes to be excluded: _____
10. Insurance requested for: ☐ Employees Only Employees and Dependents
    Should the plan provide coverage for domestic partners as permitted by P.L. 2003, c. 246? ☐ Yes ☐ No
11. Is the employer subject to the requirements of COBRA? ☐ Yes ☐ No
12. Waiting period before employees become insured: (may not exceed 6 months) Present Employees: _____ New or Rehired Employees: _____
13. What percentage of the premium will the employer pay? _____ 14. Deposit $ _____

Premium Paid: ☐ Monthly ☐ 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

Pediatric Dental and Family Pediatric Dental *(check one)* **Marketplace certified**	☐ Horizon Young Grins Stand Alone Pediatric Dental (SAPD) (only provides benefits for members under age 19) ☐ Horizon Family Grins ☐ Horizon Family Grins Plus
Family Dental	☐ Horizon Dental Option* ☐ Horizon Dental Companion ☐ Horizon Healthy Smiles** ☐ Horizon Dental PPO* ☐ Horizon Dental Choice ☐ Horizon Healthy Smiles Plus** ☐ Horizon Dental PPO Access * If a Horizon Dental Option or Horizon Dental PPO plan is selected, please provide copy of prior carrier bill. If prior carrier bill is not received, group will be subject to 6 month wait before becoming eligible for major services and orthodontic services (if applicable). Prior dental coverage does not include a dental discount plan. **If a Horizon Healthy Smiles plan is selected, please answer the following questions: Does the employer currently have dental coverage? ☐ Yes ☐ No If yes, please provide the following: Dental Carrier Name: _____ Dental Group #: _____ Is the dental coverage a pediatric dental only plan, a dental discount plan or a preventive only plan? ☐ Yes ☐ No

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

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.

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, Inc. to make or modify any request or application for insurance or to bind Horizon Healthcare Dental, Inc. on behalf of Horizon Blue Cross Blue Shield of New Jersey, Inc. 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, Inc. 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

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