



Horizon Blue Cross Blue Shield of New Jersey

Small Employer Health Plus Plan

NEW CASE SUBMISSION MATERIALS CHECKLIST

- 1) Submit Bundled Benefit and Rate Sheet (pdf generated by HealthConnect) **OR** applicable plan benefits sheet within marketing brochure.
- 2) Complete the following applications:
 - a. Application for Dental and Vision Benefits Through Small Employer Health Plus- form 32337
 - i. Low package option- Horizon Family Grins and Horizon Vista II
 - ii. High package option– Horizon Family Grins Plus and Horizon Panorama IV (Alt B)
 - b. USABLE* Application-form SG2-APP-NJ(5-09)
 - i. Complete highlighted sections only.
 - ii. Groups with the following SIC codes are ineligible: 14xx, 2892-2899, 3292, 45xx, 7381, 88xx, 9999
 - iii. Beneficiary forms are retained by the group.

Important notes:

- Please note that when the group is already enrolled in a Horizon Small Employer health plan, no deposit premium is required.
- For employees who waived health coverage and would like to enroll in Small Employer Health Plus, submit completed Enrollment/Change Request forms.

- 3) Submit applications to your Horizon Master Broker.

*USABLE Life is an independent company that operates separately from Horizon BCBSNJ. USABLE Life does not sell or service Horizon BCBSNJ products and is solely responsible for the life, disability and accident products referenced herein. Life insurance policy is issued and billed directly by USABLE. Please call (800) 370-5856 for questions regarding the Life and AD&D portion of the program.



Horizon Blue Cross Blue Shield of New Jersey

APPLICATION FOR DENTAL AND VISION BENEFITS THROUGH A SMALL EMPLOYER HEALTH PLUS PLAN

Vision benefits are provided by Horizon Insurance Company and Dental Benefits are provided by Horizon Health Services.

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: _____

3. Main Address: _____
Street City State ZIP

Mailing Address (Billing): _____
Street City State ZIP

Telephone: ___-___-___ Facsimile: ___-___-___ Email Address _____

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 full-time employees in your company: _____ 8. Number of full-time employees to be insured: _____
(Full-time 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 including Spouse Employees and Dependents excluding Spouse

11. Is the employer subject to the requirements of COBRA? ___ Yes ___ No

12. Waiting period before employees become insured:
Present employees: ___ No waiting period ___ One month ___ Two months ___ 90 days
New or rehired employees: ___ No waiting period ___ One month ___ Two months ___ 90 days

13. Deposit \$ (if applicable) _____
Premium Paid: ___ Monthly ___ Automatic checking withdrawal

SECTION II: SPECIFICATIONS FOR COVERAGE

Select one of the following:

Low package option
Horizon Family Grins
Horizon Vista II

High package option
Horizon Family Grins Plus
Horizon Panorama IV

SECTION III: 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, Inc. and/or Horizon Healthcare Services, 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

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.

Services and products may be provided by Horizon Blue Cross Blue Shield of New Jersey, Horizon Healthcare of New Jersey, Inc., Horizon Healthcare Dental, Inc., and products and policies may be provided by Horizon Insurance Company, each of which is an independent licensee of the Blue Cross and Blue Shield Association. Communications are issued by Horizon Blue Cross Blue Shield of New Jersey in its capacity as administrator of programs and provider relations for all its companies. The Blue Cross® and Blue Shield® names and symbols are registered marks of the Blue Cross and Blue Shield Association. The Horizon® name and symbols are registered marks of Horizon Blue Cross Blue Shield of New Jersey. © 2018 Horizon Blue Cross Blue Shield of New Jersey. Three Penn Plaza East, Newark, New Jersey 07105-2200

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 AND VISION ENROLLMENT USE

Coverage Code	
TOTAL APPLICATIONS SUBMITTED	
TRANSFER FROM GROUP # _____	
EMPLOYER CONTRIBUTION	
EFFECTIVE DATE	
FUTURE RATE RENEWAL DATE	

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



SMALL GROUP INSURANCE APPLICATION (GIIM)

P.O. Box 1650
Little Rock, Arkansas 72203

Type or Print in Black Ink

SECTION I. GROUP INFORMATION:

1. Legal Name of Policyholder:		2. Taxpayer ID#:		3. Effective Date of Coverage:		
4. Type of Company: <input type="checkbox"/> Corporation <input type="checkbox"/> LLC <input type="checkbox"/> PC <input type="checkbox"/> S-Corp <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Partnership <input type="checkbox"/> Government <input type="checkbox"/> Other _____						
5. Nature of Business		6. SIC Code	7. Name of Subsidiary or Affiliate Companies to be Covered		8. SIC Code/Affiliate	
9. Mailing Address of Policyholder			City	State	Zip+4	
10. Contact Information at Company: <input type="checkbox"/> Benefits or <input type="checkbox"/> Billing Contact Person _____ Phone/Fax Number _____ E-mail Address _____ Web Address _____						
11. Class Definitions. Small Group is limited to three classes with a minimum of 2 employees/class. <i>Voluntary plans are limited to one class.</i>						
Class	Life	LTD	Grp.	Vol.	Description of Class	Waiting Period, if Different
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

12. Do you have any employees located in states other than the Policyholder's main address? (If yes, please indicate states below) <input type="checkbox"/> Yes <input type="checkbox"/> No _____		13. Billing Method: <input type="checkbox"/> Credit Card/Bank draft <input type="checkbox"/> Billed by Blue Plan <input type="checkbox"/> Self Administered <input type="checkbox"/> On-Line Billing <input type="checkbox"/> List Bill	
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14. Total number of eligible employees: Group: _____ Voluntary: N/A _____		15. Total number of employees enrolled: Group: _____ Voluntary: N/A _____		16. Employer contribution: Group: _____ Voluntary: N/A _____	
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17. Waiting Period: <input type="checkbox"/> First of the following month after completion of _____ days, or <input type="checkbox"/> Day following Hire Date (VLTD requires a 30 day minimum waiting period.)		18. Minimum hours per week: Group: _____ Voluntary: N/A _____	
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19. Eligible Waiting Period Applies to: <input type="checkbox"/> Future Employees Only <input type="checkbox"/> Present & Future Employees <i>Does the waiting period apply to employees rehired within 12 months of their termination date</i> <input type="checkbox"/> Yes <input type="checkbox"/> No			19a. Annual Enrollment date for Voluntary Coverage: N/A _____		
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20. Replacement: Are any of the following a replacement of similar coverage? <i>If prior coverage, please include a copy of the prior carrier's plan.</i>						
Yes	No	Grp.	Vol.	Coverage	If Yes, Previous Carrier	Termination Date
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Life & AD&D Insurance		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Long Term Disability		

SECTION II. EMPLOYER BENEFIT OPTIONS: FOR GROUPS WITH 2 TO 50 ELIGIBLE EMPLOYEES

SELECT COVERAGES THAT BEST MEET THE GROUP'S NEEDS. Term Life/AD&D is required for LTD purchase.

STEP 1: Select the Life/AD&D and LTD Coverage for the Employees and the Class Applicable for that Amount

Group Term Life and AD&D Insurance				Group Long Term Disability					
Choice	Class (Circle one)	No. of ee's	Term Life and AD&D Benefit	Choice	Class (Circle one)	No. of ee's	LTD Benefit	Duration	
								5 YR RBD	65 RBD
<input type="checkbox"/>	1, 2, 3	_____	\$25,000	<input type="checkbox"/>	1, 2, 3	_____	\$500	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	1, 2, 3	_____	\$35,000	<input type="checkbox"/>	1, 2, 3	_____	\$750	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	1, 2, 3	_____	\$40,000*	<input type="checkbox"/>	1, 2, 3	_____	\$1,000	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	1, 2, 3	_____	\$50,000*	<input type="checkbox"/>	1, 2, 3	_____	\$1,500*	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	1, 2, 3	_____	\$2,000*	<input type="checkbox"/>	<input type="checkbox"/>

*Requires a minimum of 5 eligible employees participating. Amounts between classes may not exceed 2x the lower amount.

STEP 2: Select Enhancements to the Group Coverages			
<input type="checkbox"/>	Dependent Life Coverage: Spouse**/child: \$5,000/\$2,000 (<i>Child coverage from 14 days to 6 months is limited to \$100</i>)	<input type="checkbox"/>	Double the amount of the AD&D benefit.
SECTION III. EMPLOYEE BENEFIT OPTIONS (VOLUNTARY PLANS): FOR GROUPS WITH 10 TO 50 ELIGIBLE EMPLOYEES			
<i>Instructions: Group must elect Group Term Life/AD&D if VGTL/VAD&D or VLTD is desired. The employer cannot offer both group LTD and voluntary LTD.</i>			
<input type="checkbox"/> Voluntary* Term Life & AD&D	Benefits		
Employee (Life & AD&D)	Available amounts from \$20,000 to \$50,000 in \$10,000 increments		
Dependent (Life only – spouse**/child)	Available amounts of \$10,000/\$5,000 or \$20,000/\$10,000		
<input type="checkbox"/> Voluntary* LTD	<input type="checkbox"/> 5 yr RBD or <input type="checkbox"/> To Age 65 RBD		<i>The employer elects duration and one monthly benefit amount for all employees. The employee elects to purchase.</i>
Available Monthly Benefit Amounts	<input type="checkbox"/> \$500; <input type="checkbox"/> \$750; <input type="checkbox"/> \$1,000; <input type="checkbox"/> \$1,500		
<i>*All voluntary plans require a minimum of 10 eligible employees, with a minimum of 5 participating or 25%, whichever is greater</i>			
TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT FEATURES:			
Group and Voluntary AD&D Riders		Benefits reduce by the following amounts on the insured's birthday*	
<i>Group & Voluntary Plans</i>	<i>Voluntary Plans</i>	Reduction at Age of Employee	
<input checked="" type="checkbox"/> Seat Belt /Air Bag	<input checked="" type="checkbox"/> Special Education	Age 65	Age 70
<input checked="" type="checkbox"/> Coma	<input checked="" type="checkbox"/> Spouse** Training	<input checked="" type="checkbox"/> 35%	<input checked="" type="checkbox"/> 50%
<input checked="" type="checkbox"/> Repatriation		* Benefits for the covered person(s) terminate when no longer eligible or at retirement, whichever comes first.	
<input checked="" type="checkbox"/> Exposure and Disappearance			
LONG TERM DISABILITY FEATURES:			
Disability Definition: Earnings / Occupation Test (80/20);24 month own occupation		Drug & Mental Illness Limitation: 24 Month Lifetime Benefits	
Elimination Period: 180 Days (Group & Voluntary)		Benefit Percentage: Flat benefit not to exceed 60% of pre-disability earnings	
Pre-existing Condition:Group LTD: 3/12; Voluntary LTD: 12/6/24		Integration: non-integrated; Voluntary amounts above \$1,000 are integrated.	
W-2 Service Options for Long Term Disability			
<input type="checkbox"/> Option 1: Withhold Federal income Taxes and the employee's portion of FICA. Prepare and File W-2 Forms. <input type="checkbox"/> Option 2: Withhold Federal income Taxes and the employee's portion of FICA. Policyholder waives W-2 Forms Services. A detailed description of the W-2 services elected by the Policyholder pursuant to this application will be sent to the Policyholder by mail. Such services will be performed in accordance with the above election and established standard procedures.			
<i>** Spouse means a spouse or civil union partner. A civil union is defined as a relationship that meets the requirements pursuant to New Jersey's Civil Union Act and includes same-sex relationships from other jurisdictions that provide substantially all of the rights and benefits of marriage.</i>			
SECTION IV. AUTHORIZATION:			
REMARKS OR SPECIAL PROVISIONS:			
<p>The undersigned employer and /or authorized representative hereby: (a) request that it be approved for insurance coverage through USABLE Life and agree to comply with all terms and provisions of the Group Policy (ies) issued in response to this application; (b) certify that the statements and answers given in this application are true, complete and correctly recorded to the best of their knowledge and belief</p> <p>It is understood and agreed that this application shall be made a part of the policy or policies applied for and that no insurance shall be effective until approved by USABLE Life.</p> <p>Warning: Any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.</p>			

_____ Dated at (City & State)

_____ Date

_____ Signature of Policyholder and Title

_____ Name of Licensed Agent

_____ Signature of Licensed Agent

For Home Office Use Only

Group #