Small Employer Health Plus Plan
along with a Small Employer Health 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 a Small Group Health Benefits Policy – form 32327 (0123)
      i. Select Horizon Family Grins for low package option
      ii. Select Horizon Family Grins Plus for high package option

   b. Application for Vision Benefits through Small Employer Health Plus- form 32335 (0918)
      i. Select Horizon Vista for low package option
      ii. Select Horizon Panorama IV (Alt B) for high package option

   c. USAble* Application-form ICC21-SG2-APP (3-21)
      i. Complete application
      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:
   - Deposit premium is required for the health plan.
   - For Dental and Vision, you must select either both low package options or both high package options.
   - 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.

Small Employer Group Application Instructions

Instructions

The attached forms should be completed with the assistance of your authorized Broker or Horizon Blue Cross Blue Shield of New Jersey Sales Representative.
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.** The Officer, Partner, Owner and / or Correspondent signing the application must be listed on the New Jersey Small Employer Certification.

Completed enrollment application forms should be sent to your authorized Broker or Horizon BCBSNJ Sales Representative **prior to your effective date.**

Documents Included

Attached you will find the forms that must be completed and submitted for each New Jersey small employer group applying for standard health insurance coverage:

- Application for a Small Employer Health Benefits Policy.
- New Jersey Small Employer Certification.
- Small Employer Health Benefits Waiver of Coverage – One form is needed for each employee waiving or refusing coverage. This form may be photocopied as needed.

Other Required Documents

In addition to the forms listed above, **depending on group size / composition and preferred payment method, the following items may also be required:**

- Payroll verification through appropriate tax documentation, i.e., WR30 (required for groups of five or fewer eligible).
- Owner payroll documentation (K-1, Schedule C and/or 1120).
- Where there is an affiliated company, a Small Employer Common Ownership Certification form.
- Automatic Pay Plan Application (#8977).

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

- Enrollment Change / Request Form (#6803) – One form is needed for each employee enrolling. Your authorized Broker or Horizon BCBSNJ Sales Representative will provide these forms.
- First month's premium – All new cases must be submitted with a company check for the first month's premium payable to Horizon BCBSNJ. If a case is submitted without a premium check, the case will be returned.
- Prior / Current Carrier's most recent billing statement – Required if replacing group medical coverage.
- Rate Quote – The rate quote generated for the group should match the product(s) selected in Section II of the Application for a Small Employer Health Benefits Policy.

Rate Quotes

The rate quote is an estimate based on information provided by your authorized Broker or Horizon BCBSNJ Sales Representative. If there is inaccurate or missing information on the original quote, the rate may change based on an official review of the paperwork submitted to Horizon BCBSNJ.

Submission of Application to Horizon BCBSNJ

Your authorized Broker will submit this Application to Horizon BCBSNJ.

RESET

APPLICATION FOR A SMALL GROUP HEALTH BENEFITS POLICY

Please print or type Policy Number: _____ ☐ New Policy ☐ Change in Policy Requested Effective Date: _____

Note: The Effective Date will be on or after the date Horizon Blue Cross Blue Shield of New Jersey approves the application.

SECTION I: POLICYHOLDER INFORMATION

1. Policyholder (full legal name of company): _____

2. Tax Identification Number: _____

3. Main Address: _____
   Street City State ZIP

   Mailing Address: _____
   Street City State ZIP

   Telephone: _____ Facsimile: _____ Email Address: _____

   Contract information should be provided: ☐ electronically or ☐ hard copy. Check one.

4. Correspondent: _____ 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: _____
   Refer to the New Jersey Small Employer Certification for the definition of a full-time employee.

8. Number of full-time employees to be insured: _____ 9. Class or classes to be excluded: _____

10. Insurance Requested For:
    ☐ Employees Only ☐ Employees and Dependents including Spouse ☐ Employees and Dependents excluding Spouse

    Should the plan provide coverage for domestic partners as permitted by P.L. 2003, c. 246? ☐ Yes ☐ No
    If yes, should the plan provide coverage for coverage of children of a covered domestic partner? ☐ Yes ☐ No

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

12. Is the employer subject to the requirements of Medicare as Secondary Payor Rules for eligibility due to age? ☐ Yes ☐ No
    Due to disability? ☐ Yes ☐ No

13. Orientation Period? ☐ Yes ☐ No

14. Waiting period before employees become insured: (may not exceed 90 days)
    Present Employees : ☐ no waiting period ☐ one month ☐ two months ☐ 90 days
    New or Rehired Employees: ☐ no waiting period ☐ one month ☐ two months ☐ 90 days

15. Period for Annual Employee Open Enrollment Period: _____

16. What percentage of the premium will the employer pay? _____

17. Deposit $ _____

Premium Paid: ☐ Monthly ☐ Automatic checking withdrawal
Premium will be due as of the effective date. The premium for the first month of coverage must be attached.

Affiliates, subsidiaries or branches (Must be included for purposes of participation)

Legal Name & Location	No. of full-time employees in this company	No. of full-time employees to be insured

SECTION II: SPECIFICATIONS FOR COVERAGE

Please select desired health benefits option and stand alone pediatric dental option.

HEALTH BENEFITS

Advantage Direct Access

☐ Platinum 100/70 - $20/$40 copay, $10/$25/$50 Rx, with BlueCard

☐ Gold 100/80/60 - $30/$50 copay, $15/$40/$75 Rx, with BlueCard

Advantage EPO

☐ Gold 100 - $25/$45 copay, $25/$50/$75 Rx
☐ with BlueCard ☐ without BlueCard

☐ Gold 100 - $40/$60 copay, $15/60%/50% Rx
☐ with BlueCard ☐ without BlueCard

☐ Gold 100/80 - $20/$40 copay, $10/$25/$50 Rx
☐ with BlueCard ☐ without BlueCard

☐ Silver 100/60 - $45/$70 copay, $25/$50/$75 Rx
☐ with BlueCard ☐ without BlueCard

☐ Silver 100/50 - $30/$65 copay, $20/$50/$75 Rx
☐ with BlueCard ☐ without BlueCard

☐ Bronze 50 - 50% after deductible, $25/50% after deductible Rx
☐ with BlueCard ☐ without BlueCard

OMNIA

☐ OMNIA Platinum, $5/$15/$30/$30 Rx, without BlueCard
☐ OMNIA Platinum Value, $10/$25/$50/$50 Rx, without BlueCard
☐ OMNIA Gold, $10/$40/$75/$75 after Tier 1 Rx deductible, without BlueCard
☐ OMNIA Silver, $25/50%, 50%, 50% after Tier 1 Rx deductible, without BlueCard
☐ OMNIA Silver Value, $10/$40/$75/$75, after Tier 1 deductible, without BlueCard
☐ OMNIA Bronze, $25/50%, 50%, 50% after Tier 1 deductible, without BlueCard
☐ OMNIA Gold, $10/$40/$75/$75 Rx, with BlueCard
☐ OMNIA Silver, $25/50%/50%/50% after Tier 1 Rx deductible, with BlueCard

HSA plans

☐ OMNIA Silver HSA, Tier 1 deductible & 60% Rx, without BlueCard
☐ OMNIA Gold HSA, $10/$40/$75/$75 after Tier 1 deductible, with BlueCard
☐ HSA Advantage Direct Access Silver 100/70/60 - $30/$50 copay after deductible, 60% CDHRx, with BlueCard

☐ **Other:** _____

STAND ALONE PEDIATRIC DENTAL

☐ Horizon Young Grins (only provides benefits for members under age 19)
☐ Horizon Family Grins
☐ Horizon Family Grins Plus

STAND ALONE PEDIATRIC DENTAL OPTIONS

The Patient Protection and Affordable Care Act (PPACA) permits plans outside of the Small Employer Business Health Options (SHOP) Program to issue coverage without pediatric dental benefits only if reasonably assured that the applicant has purchased an exchange-certified stand-alone dental plan (SAPD) covering the pediatric dental benefits as required by PPACA. In order to receive reasonable assurance from you, we require the following information if you did not select a Stand Alone Pediatric Dental Plan listed above:

☐ Proof of coverage or other documentation reasonably acceptable to the Health Insurance Issuers evidencing your enrollment in an exchange certified SAPD. Proof acceptable may be a copy of enrollment confirmation from the SAPD issuer or a copy of your coverage document (for example, a certificate of coverage).

☐ The contact information of your SAPD issuer that we may verify your enrollment with, which you expressly grant our ability to verify your enrollment:

Name of SAPD Issuer: _____

Policy Number: _____

Name of Contract Holder: _____

SECTION III: ALL QUESTIONS MUST BE ANSWERED

1. Is there any Group Health Plan:
   - now in force and to be continued? ☐ Yes ☐ No
   - currently being applied for? ☐ Yes ☐ No

   If "Yes", identify the name of the Group Health Plan, give a description of the plan(s) and name of insurance carrier(s):_____

   _____

2. 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 _____

   Plan being replaced: _____

3. Are extended benefits provided in case of termination of health benefits? ☐ Yes ☐ No

4. To the best of your knowledge are there any current or former employees or their eligible dependents whose health insurance is being continued? ☐ Yes ☐ No

Please provide the following information for each current/former employee or dependent on health continuations.

Name of Employee/Dependent	Date of Birth	Type of Continuation State/Federal/ Extended Benefits	Reason for Termination Disability/Other	Continuation Dates Start	Continuation Dates End

If additional space is needed, attach a separate sheet, signed and dated.

5. To the best of your knowledge:
   a. Are any employees or dependents presently incapacitated? ☐ Yes ☐ No
   b. Are any dependent children incapable of self-support due to a physical or mental disability? ☐ Yes ☐ No

Additional space to explain if items 1, 2 or 3 were answered "Yes". Refer to the question number, and give details including names, where appropriate.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

6. Does the employer participate in an arrangement with a Professional Employer Organization? ☐ Yes ☐ No
   (Refer to Advisory Bulletin 00-SEH-02 if you need information concerning what constitutes a Professional Employer Organization.)

SECTION IV: AGENT/PRODUCER INFORMATION AND UNDERWRITING GROUP ENROLLMENT USE

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 ____________

SUB-PRODUCER INFORMATION AND COMMISSION SPLIT

Sub-Producer Information (This information must be answered completely)

SUB-PRODUCER SIGNATURE ____________ DATE ____________ NPN NUMBER ____________

SUB-PRODUCER NAME ____________ NAME OF AGENCY ____________ TELEPHONE NUMBER ____________

STREET ____________ CITY ____________ STATE ____________ ZIP CODE ____________

____________%
Sub-Producer Commission Percentage

SUB-PRODUCER SIGNATURE ____________ DATE ____________ NPN NUMBER ____________

SUB-PRODUCER NAME ____________ NAME OF AGENCY ____________ TELEPHONE NUMBER ____________

STREET ____________ CITY ____________ STATE ____________ ZIP CODE ____________

____________%
Sub-Producer Commission Percentage

SUB-PRODUCER SIGNATURE ____________ DATE ____________ NPN NUMBER ____________

SUB-PRODUCER NAME ____________ NAME OF AGENCY ____________ TELEPHONE NUMBER ____________

STREET ____________ CITY ____________ STATE ____________ ZIP CODE ____________

____________%
Sub-Producer Commission Percentage

SUB-PRODUCER SIGNATURE ____________ DATE ____________ NPN NUMBER ____________

SUB-PRODUCER NAME ____________ NAME OF AGENCY ____________ TELEPHONE NUMBER ____________

STREET ____________ CITY ____________ STATE ____________ ZIP CODE ____________

____________%
Sub-Producer Commission Percentage

SPECIAL INSTRUCTIONS

For Internal Underwriting Use

☐ Approved for _____ Number of Subscribers _____

☐ Declined

Underwritten By _____ Date _____

For Internal Group Enrollment Use

	ADV DA	ADV EPO	OMNIA	HSA ADV DA	HSA ADV EPO	OMNIA HSA	OTHER	Rx	DENTAL	SAPD
COVERAGE CODE c/o										
TOTAL APPLICATIONS SUBMITTED										
TRANSFER FROM GROUP # _____										
REFUSALS/WAIVERS LISTING ATTACHED (IF APPLICABLE)										
EMPLOYER CONTRIBUTION										
EFFECTIVE DATE										
FUTURE RATE RENEWAL DATE										

APPROVED BY: _____ _____

REVIEWER SIGNATURE DATE APPROVED

SECTION V: SIGNATURE

It is understood that, except as provided under applicable regulations, no individual shall become insured while not actively at work on a full-time basis, and only full-time employees are eligible. (Refer to the definition on the New Jersey Employer Certification.) 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 Blue Cross Blue Shield of New Jersey 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. Final rates will be based on enrollment data as of the Policy effective date. No contract of insurance is to be implied in any way on the basis of the completion and/or submission of this application.

It is understood that I am responsible to provide Horizon Blue Cross Blue Shield of New Jersey with timely and accurate information regarding the date of hire for new employees and that the requested effective date of coverage will properly apply any orientation period and waiting period requirements applicable to my plan. It is further understood that any retroactive termination requests must be limited to those for which no premium or contribution has been paid for the termination period by the employee or dependent whose coverage is to be retroactively terminated.

☐ Please read this statement and check to confirm. I confirm that I have received the Summary of Benefits and Coverage (SBC) documents associated with the plan or plans I selected on this application. I confirm I will provide SBCs to plan participants and beneficiaries as required by federal regulations and guidance related to the distribution of the SBC, including the requiring for timing and delivery.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Dated at _____ on _____

_____ _____

Print name of Officer, Partner or Proprietor

Signature of Officer, Partner or Proprietor

_____

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

NEW JERSEY SMALL EMPLOYER CERTIFICATION

Legal Name and Address of Employer: _____
Name

_____
Street City State ZIP

Group Policy Number or Group Number: _____
(if a current customer)

For purposes of certification as a New Jersey Small Employer, an Employer is considered to be a Small Employer if the Employer satisfies the definition set forth below.

Employee and Small Employer Definitions
The definition of Small Employer counts employees as defined below.

Employee means an employee of the Policyholder. An individual and his or her legal spouse when the business is owned by the individual or by the individual and his or her legal spouse, partners in a partnership, sole proprietors, a 2-percent S corporation shareholder and independent contractors are **not** employees of the Policyholder.

Small Employer means in connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding Calendar Year and who employs at least 1 employee on the first day of the Plan Year.

All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer.

In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

The following calculation must be used to determine if an employer employs at least 1 but not more than 50 employees. For purposes of this calculation:

a) Employees working 30 or more hours per week are full-time employees and each full-time employee counts as 1;

b) Employees working fewer than 30 hours per week are part-time and counted as the sum of the hours each part-time employee works per week multiplied by 4 and the product divided by 120 and rounded down to the nearest whole number.

Add the number of full-time employees to the number that results from the part-time employee calculation. If the sum is at least 1 but not more than 50 the employer employs at least 1 but not more than 50 employees.

Please note: Small Employer includes an employer that employs more than 50 full-time employees if the employer's workforce exceeds 50 full-time employees for no more than 120 days during the calendar year and the Employees in excess of 50 who were employed during such 120-day or fewer period were seasonal workers.

Full-Time Employee Definition
The definition of Full-time Employee is used to determine eligibility for coverage under a small employer plan. Full-time employees are counted when determining participation for a small employer.

Full-Time Employee means an employee who works a normal work week of 25 or more hours. Work must be at the Policyholder's regular place of business or at another place to which an employee must travel to perform his or her regular duties for his or her full and normal work hours.

Please note that the above definition of Small Employer above considers full-time to be 30 hours per week and that definition of full-time is used solely for determining whether an employer is a Small Employer. For purposes of determining which employees are eligible for insurance under a Small Employer plan and whether the Small Employer meets the participation requirement, full-time is defined as 25 hours per week.

Please indicate below the number of employees by work location/State. Refer to the definition of "employee" on page 1. All employees must be included, regardless of whether or not they currently have medical coverage and through whom that coverage is provided.

Work Location (list by State)	Number of Employees or Former Employees			
	Full-time	Part-time	COBRA or State Continuees	Other

The following information will be used to calculate the **participation** rate. Refer to the definition of "full-time employee" on page 1 that counts employees working 25 or more hours per week.

Total # Full-time Employees _____

Total # Full-time Employees applying/enrolling for health benefits coverage _____

Total # Full-time employees waiving health benefits coverage under the policy with coverage under their spouse's or parent's group coverage, Medicare, Medicaid, or NJ FamilyCare or Tricare or any other group Health Benefits Plan **through a different employer** _____

Total # Full-time employees waiving health benefits coverage under the policy with coverage under a Health Benefits Plan **issued by another carrier and offered by the small employer**: _____

Please separately list the name(s) of the other carrier(s) and the number of employees covered under each:

_____ _____

_____ _____

Total # Full-time employees waiving health benefits coverage under the policy without coverage under a spouse's or parent's group coverage; Medicare, Medicaid, or NJ FamilyCare or Tricare or any other Health Benefits Plan _____

Total # Employees in an ineligible class or classes _____

The following information will be used to determine how certain federal laws apply to the Small Employer.

Is your firm subject to Working Aged Provisions of federal law (TEFRA/DEFRA)? ☐ Yes ☐ No
(You may be subject to the law if you employed 20 or more employees for 20 weeks in the current or prior calendar year)

If yes, provide the number of full-time and part-time employees you employed for at least 20 or more weeks in the current or prior calendar year. _____

For purposes of this question "employee" includes: full-time employees, part-time employees, seasonal employees, temporary employees, employees who are union members, owners, partners, officers and excludes self-employed persons, independent contractors (1099), directors

Is your firm subject to the requirements of the federal COBRA law? ☐ Yes ☐ No

(You may be subject to the law if you employed 20 or more employees during 50% or more of the working days during the previous calendar year.)

For purposes of this question "employee" includes: full-time employees, part-time employees, seasonal employees, temporary employees, employees who are union members, owners, partners, officers and excludes self-employed persons, independent contractors (1099), directors.

If yes, provide the number of full-time and part-time employees you employed during 50% or more of the working days during the previous calendar year. _____

Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours the part-time employee worked divided by the hours an employee must work to be considered full-time.

CERTIFICATION AS A SMALL EMPLOYER IN THE STATE OF NEW JERSEY

For a Group Health Benefits Plan

Please sign and date appropriate section indicating whether or not you meet the definition of a small employer .

☐ I certify that I qualify as a Small Employer in the State of New Jersey.)

AND

☐ I certify that the information provided to Horizon Blue Cross Blue Shield of New Jersey is true and complete. I understand that if the above information is not complete or is not provided to Horizon BCBSNJ, in a timely manner, then health benefits coverage does not have to be offered or continued. I further understand that incomplete or untrue information may void health benefits coverage.

☐ I certify that I have obtained and maintain a stand-alone pediatric dental plan for all employees and dependents enrolling for health benefits coverage.

_____ _____

Signature of Officer, Partner or Owner *Title*

_____ _____

Print Name of Officer, Partner or Proprietor Date

_____ _____

Signature of Witness Date

☐ **I certify that I am NOT a Small Employer in the State of New Jersey, as defined above.**

_____ _____

Signature of Officer, Partner or Proprietor *Title*

_____ _____

Print Name of Officer, Partner or Proprietor Date

_____ _____

Signature of Witness Date

Any person who includes any false or misleading information on an application or enrollment form or certification for a health benefits plan is subject to criminal and civil penalties.

Complete this section if you have certified that the Employer is a Small Employer

***CENSUS INFORMATION**

Please include the following persons in the following list:

a. employees, owners, partners, and officers who are actively working for the employer on a regular basis, and are paid by the employer on a regular basis, whether or not they are eligible to be covered under the policy.

b. employees, owners, partners and officers who are not working, but who are currently covered under the employer's health benefits plan for reasons such as continuation of coverage or total disability.

Please use the following letters to indicate Status:

O: Owner, partner or officer
F: Full-time employee who works 25 or more hours per week
P: Part-time employee who works less than 25 hours per week
S: Seasonal employee (employee works 120 days or fewer per year)
D: Totally Disabled employee
C: Continuee under state or federal law
U: Employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement.

Name	Job Title	Date of Employment	Hours Worked Per Week	Status	Work Location (State)	Date of Birth
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						

*If additional space is needed, attach a separate sheet.

SMALL EMPLOYER HEALTH BENEFITS WAIVER OF COVERAGE

Group Policy No.: _____

Policyholder Name: _____

Employee Name: _____
Last First MI

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Date of Employment: _____ Date of Birth: _____

I was given the opportunity to enroll in this plan of group health benefits offered by my employer and insured by Horizon Blue Cross Blue Shield of New Jersey. I *refuse* the following:

☐ Employee, Spouse and Child(ren) coverage

☐ Spouse coverage

☐ Child(ren) coverage

Reason for Refusal (Please check all appropriate boxes.)

☐ other fully-insured Group Health Plan sponsored by this employer

☐ other Group Health Plan sponsored by my spouse's employer

☐ other group coverage sponsored by another organization

☐ covered under Medicare

☐ other reasons (please explain) _____

Please identify Group Health Plan(s) and provide names(s) of policyholder(s), carrier(s) and policy number(s).

Policyholder/Name: _____ _____ _____
Last First MI

Carrier: _____ Policy Number: _____

Policyholder/Name: _____ _____ _____
Last First MI

Carrier: _____ Policy Number: _____

Policyholder/Name: _____ _____ _____
Last First MI

Carrier: _____ Policy Number: _____

If you are declining enrollment for yourself or your dependents (including your spouse) because of other Group Health Plan coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 90 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days after marriage, birth, adoption or placement for adoption.

I understand that if I later wish to enroll for any of the coverage(s) refused, I will be required to submit an Enrollment Form.

_____ Date: _____ / _____ / _____
Signature of Employee MM DD YYYY

_____ Date: _____ / _____ / _____
Signature of Witness MM DD YYYY

APPLICATION FOR VISION BENEFITS THROUGH A SMALL EMPLOYER HEALTH PLUS PLAN

Horizon Insurance Company is the affiliate company for Vision benefits.

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

SECTION II: SPECIFICATIONS FOR COVERAGE

Select one of the following:

☐ **Low package option**
Horizon Vista II

☐ **High package option**
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 Insurance Company 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.

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 VISION 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

USAble Life℠

SMALL GROUP INSURANCE APPLICATION (GIIM)

Type or Print in Black Ink

P.O. Box 1650
Little Rock, Arkansas 72203

SECTION I. GROUP INFORMATION:

1. Legal Name of Policyholder: | 2. Taxpayer ID#: | 3. Effective Date of Coverage:

4. Type of Company: ☐ Corporation ☐ LLC ☐ PC ☐ S-Corp ☐ Sole Proprietor ☐ Partnership ☐ Government ☐ 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:

☐ Benefits or ☐ 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. *Voluntary plans are limited to one class.*

Class	Life	LTD	Grp.	Vol.	Description of Class	Waiting Period, if Different
	☑	☐	☐	☐	All active full time employees enrolled in the Small Employer Health Plus Plan	
	☐	☐	☐	☐		
	☐	☐	☐	☐		

12. Do you have any employees located in states other than the Policyholder's main address? (if yes, please indicate states below)
☐ Yes ☐ No States:_____

13. Billing Method:
☐ Self-Administered
☐ Online Billing ☑ List Bill

14. Total number of eligible employees:
Group: _____ Voluntary: N/A

15. Total number of employees enrolled:
Group: _____ Voluntary: N/A

16. Employer contribution:
Group: 100 Voluntary: N/A

17. Do you allow Domestic Partner Coverage under the existing Medical Plan? ☐ Yes ☐ No

18. Waiting Period: ☐ First of the following month after completion of _____ days, or
☐ Day following Hire Date (*VLTD requires a 30 day minimum waiting period.*)

19. Minimum hours per week:
Group: 25 Voluntary:_____

20. Eligible Waiting Period Applies to: ☐ Future Employees Only ☐ Present & Future Employees
Does the waiting period apply to employees rehired within 12 months of their termination date ☐ Yes ☐ No

20a. Annual Enrollment date for Voluntary Coverage: N/A

21. Replacement: Are any of the following a replacement of similar coverage? *If prior coverage, please include a copy of the prior carrier's plan.*

Yes	No	Grp.	Vol.	Coverage	If Yes, Previous Carrier	Termination Date
☐	☑	☐	☐	Life & AD&D Insurance		
☐	☐	☐	☐	Long Term Disability	N/A	

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

Choice	Class (Circle one)	No. of ee's	Term Life and AD&D Benefit
☑	1, 2, 3	_____	$25,000
☐	1, 2, 3	_____	$35,000
☐	1, 2, 3	_____	$40,000*
☐	1, 2, 3	_____	$50,000*

Group Long Term Disability

Choice	Class (Circle one)	No. of ee's	LTD Benefit	Duration	
				5 YR RBD	65 RBD
☐	1, 2, 3	_____	$500	☐	N/A
☐	1, 2, 3	_____	$1,000	☐	N/A
☐	1, 2, 3	_____	$1,500*	☐	☐
☐	1, 2, 3	_____	$2,000*	☐	N/A

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

USAble Life℠

P.O. Box 1650
Little Rock, Arkansas 72203

SMALL GROUP INSURANCE APPLICATION (GIIM)

Type or Print in Black Ink

STEP 2: Select Enhancements to the Group Coverages			
☒	Dependent Life Coverage: Spouse/child: $5,000/$2,000 (*Child coverage from 14 days to 6 months is limited to $100)*		

SECTION III. EMPLOYEE BENEFIT OPTIONS (VOLUNTARY PLANS): *FOR GROUPS WITH 10 TO 50 ELIGIBLE EMPLOYEES*

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.

☐ **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*	
☐ **Voluntary* LTD**	☐ 5 yr RBD or ☐ To Age 65 RBD	*The employer elects duration and one monthly benefit amount for all employees. The employee elects to purchase.*
Available Monthly Benefit Amounts	☐ $500; ☐ $750; ☐ $1,000; ☐ $1,500	

**All voluntary plans require a minimum of 10 eligible employees, with a minimum of 5 participating or 25%, whichever is greater*

TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT FEATURES:

Group and Voluntary AD&D Riders		Benefits reduce by the following amounts on the insured's birthday*			
Group & Voluntary Plans	*Voluntary Plans*	Reduction at Age of Employee			
☐ Seat Belt /Air Bag/Helmet	☐ Special Education	Age 65		Age 70	
☐ Coma	☐ Spouse Training	☐	35%	☐	50%
☐ Repatriation		* Benefits for the covered person(s) terminate when no longer eligible or at retirement, whichever comes first.			
☐ 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

- ☐ Option 1: Withhold Federal income Taxes and the employee's portion of FICA. Prepare and File W-2 Forms.
- ☐ 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.

SECTION III. AUTHORIZATION

REMARKS OR SPECIAL PROVISIONS:

The undersigned employer and /or authorized representative hereby request that it be approved for insurance coverage through USAble Life and agrees to comply with all terms and provisions of the Group Policy(ies) issued in response to this application.

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.

This application is governed by the laws of the state of New Jersey.

Warning: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Dated at (City & State)	**Date**	**Signature of Policyholder and Title**
Name of Licensed Agent	**Signature of Licensed Agent**	**For Home Office Use Only** **Group #**

Notice of Nondiscrimination

Horizon Blue Cross Blue Shield of New Jersey complies with applicable Federal civil rights laws and does not discriminate against nor does it exclude people or treat them differently on the basis of race, color, gender, national origin, age, disability, pregnancy, gender identity, sex, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations. Horizon BCBSNJ provides free aids and services to people with disabilities (e.g. qualified language interpreters and information in other formats) and to those whose primary language is not English (e.g. information in other languages) to communicate effectively with us.

Contacting Member Services
Call Member Services at **1-844-498-9393** (TTY **711**) **or the phone number on the back of your member ID card**, if you need the free aids and services noted above and for **all other Member Services issues.**

Filing a Section 1557 Grievance
If you believe that Horizon BCBSNJ has failed to provide the free communication aids and services or discriminated against you for one of the reasons described above, you can file a discrimination complaint also known as a Section 1557 Grievance. Horizon BCBSNJ's Civil Rights Coordinator can be reached by calling the Member Services number on the back of your member ID card or by writing to:

Horizon BCBSNJ
Civil Rights Coordinator
PO Box 820
Newark, NJ 07101

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, online at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail at **U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201** or by phone at **1-800-368-1019** or **1-800-537-7697** (TDD). OCR Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

Language assistance
Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-844-498-9393** (TTY **711**).
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-844-498-9393**（TTY 711）.
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

1-844-498-9393 (TTY 711)번으로 전화해 주십시오.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-844-498-9393** (TTY **711**).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-844-498-9393** (TTY **711**).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-844-498-9393** (TTY **711**).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-844-498-9393** (TTY **711**).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-**844-498-9393** (رقم هاتف الصم والبكم 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-844-498-9393** (TTY **711**).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-844-498-9393** (телетайп **711**).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-844-498-9393** (TTY **711**).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपकेलिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।
1-844-498-9393 (TTY **711**) पर कॉल करें।

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-844-498-9393** (TTY **711**).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-844-498-9393** (ATS **711**).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں
1-844-498-9393 (TTY **711**).