Horizon

Horizon Blue Cross Blue Shield of New Jersey

NON-GROUP ENROLLMENT/CHANGE REQUEST

Attn: Consumer Enrollment Dept.
P.O. Box 1330
Newark, NJ 07101-1330
Fax: 973-274-4413
www.HorizonBlue.com

A. Type of Activity – to be completed by Applicant

Refer to instructions before completing this form. (Check all that apply)

1. ADD

	Date of Event	Reason		Date of Event	Reason
☐ Enrollment of a new Subscriber	____/____/____	_____	☐ Add Domestic Partner	____/____/____	_____
☐ Add Spouse	____/____/____	_____	☐ Add Dependent Child	____/____/____	_____
☐ Add Civil Union Partner	____/____/____	_____			

2. REMOVE

	Date of Event	Reason		Date of Event	Reason
☐ Remove Subscriber	____/____/____	_____	☐ Remove Domestic Partner	____/____/____	_____
☐ Remove Spouse	____/____/____	_____	☐ Remove Dependent Child	____/____/____	_____
☐ Remove Civil Union Partner	____/____/____	_____			

3. OTHER CHANGE

	Date of Event	Reason		Date of Event	Reason
☐ Name Change	____/____/____	_____	☐ Add/Change Office ID Numbers: Primary Care Provider	____/____/____	_____
☐ Change Plan	____/____/____	_____	☐ Other	____/____/____	_____
☐ Special Enrollment Period (Check triggering event below and attach proof)	____/____/____				

- ☐ Loss of minimum essential coverage
- ☐ Dependent attained age 26 or 31 and lost coverage
- ☐ Marriage/birth/adoption/foster care
- ☐ Access to new plan due to permanent move
- ☐ Marketplace changed subsidy determination
- ☐ Marketplace determination - enrollment error

B. Applicant Information

☐ Add ☐ Remove ☐ Other Change ☐ Continue *If a name change, indicate prior name:* _____

Last Name: | First Name: | MI:

Social Security #: | Date of Birth: MM DD YYYY | Sex: M F

Are you a resident of New Jersey? ☐ Yes ☐ No

Primary Residence: Street | Apt.:

City: | State: | Zip Code + 4: | Phone:

Do you maintain a home in any other state/country? ☐ Yes ☐ No *If yes:* Name of state/country: _____ Number of months you live there each year: _____

Other Residence: Street | Apt.:

City: | State: | Zip Code: | Phone:

Your billing address: ☐ Primary residence ☐ Other residence ☐ P.O. Box or Other *(specify)*: _____

Are you eligible for Medicare? ☐ Yes ☐ No Are you covered under Other Health Coverage? ☐ Yes ☐ No *If yes,* why are you applying for individual coverage and what is your intended termination date? _____

Primary Care Provider Name: | Current Patient: ☐ Yes ☐ No

Primary Care Provider Address:

City: | State: | Zip Code + 4:

NPI #: | Loc Code:

POLICYHOLDER'S LAST NAME _____ FIRST NAME _____ MI _____

C. Plan Options **Please select desired medical plan option. We cannot issue you a medical plan without a pediatric dental plan.**

Unit *(Check One)*

☐ Single ☐ Family ☐ Two Adults (Includes Domestic Partners/Civil Union Partners) ☐ Adult & Child(ren)

Medical *(Check One)*

Horizon Advantage Plans (The selection of a Primary Care Provider (PCP) is not required; however, we encourage you to select a PCP to maximize your benefits.)

☐ Horizon Advantage EPO Gold
☐ Horizon Advantage EPO Silver
☐ Horizon Patient Centered Advantage EPO Silver 20/30/30%
☐ Horizon Advantage EPO Bronze
☐ Horizon Advantage EPO Essentials. You must be under age 30 or provide a Certificate of Exemption from the Marketplace if you are age 30 or older.

Horizon Advance Plans (The selection of a PCP who participates in the Advance EPO Plan is required).

☐ Horizon Advance EPO Gold
☐ Horizon Advance EPO Silver
☐ Horizon Advance EPO Silver 40/70%
☐ Horizon Advance EPO Bronze

Pediatric Dental *(Required)*

Stand Alone Pediatric Dental (SAPD) Plan: Federal law requires coverage for pediatric dental benefits. Because the above Medical Plan Options do not contain pediatric dental benefits, you must provide assurance that you have, or will obtain a Marketplace-certified SAPD plan. **We will automatically enroll you and your covered dependents in the Horizon Young Grins SAPD plan, unless you indicate below that you have purchased a SAPD plan with another carrier. No SAPD premium will be charged for anyone age 19 or older.**

☐ I have purchased a Marketplace-certified SAPD plan with another carrier. I agree to provide information demonstrating this coverage immediately to Horizon BCBSNJ if requested, that may include the evidence of coverage, the name of the issuer and applicable policy number. I attest that this information is accurate and agree to hold Horizon BCBSNJ harmless from any harm, monetary loss, or liability in connection with reliance on your representation.

D. Other Individuals Covered *Identify individuals other than yourself for whom you are adding/changing/removing coverage. Attach additional pages if necessary, dated and signed by you. Attach proof of disability.*

1. SPOUSE/CIVIL UNION PARTNER/DOMESTIC PARTNER ☐ Add ☐ Remove ☐ Other

Last Name (If last name is different from applicant's attach proof): First Name: MI:

Social Security #: Date of Birth: MM DD YYYY Sex: M F

Home address same as applicant? ☐ Yes ☐ No

If no, provide home address and explain why the address is different: _____

Home Address: Street Apt.:

City: State: Zip Code + 4: —

Eligible for Medicare? ☐ Yes ☐ No Covered under Other Health Coverage? ☐ Yes ☐ No If yes, intended termination date: _____

Primary Care Provider Name: Current Patient ☐ Yes ☐ No

Primary Care Provider Address:

City: State: Zip Code + 4: —

NPI #: Loc Code:

2. CHILD ☐ Add ☐ Remove ☐ Other

Last Name (If last name is different from applicant's attach proof): First Name: MI:

Social Security #: Date of Birth: MM DD YYYY Sex: M F

Living with applicant? ☐ Yes ☐ No *If No, complete Section E*

Eligible for Medicare? ☐ Yes ☐ No Covered under Other Health Coverage? ☐ Yes ☐ No If yes, intended termination date: _____

Primary Care Provider Name: Current Patient: ☐ Yes ☐ No

Primary Care Provider Address:

City: State: Zip Code + 4: —

NPI #: Loc Code:

POLICYHOLDER'S LAST NAME _____ **FIRST NAME** _____ **MI** _____

3. CHILD ☐ Add ☐ Remove ☐ Other

Last Name (If last name is different from applicant's attach proof): First Name: MI:

Social Security #: Date of Birth: MM DD YYYY Sex: M F

Living with applicant? ☐ Yes ☐ No *If No, complete Section E*

Eligible for Medicare? ☐ Yes ☐ No Covered under Other Health Coverage? ☐ Yes ☐ No If yes, intended termination date: _____

Primary Care Provider Name: Current Patient: ☐ Yes ☐ No

Primary Care Provider Address:

City: State: Zip Code + 4: —

NPI #: Loc Code:

E. Additional Child Information

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

Name:

Address: Street Apt:

City: State: Zip Code + 4: —

Reason: _____

Name:

Address: Street Apt:

City: State: Zip Code + 4: —

Reason: _____

F. Race/Ethnicity

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

G. Payment Information

Indicate how you would like to make payment. Credit or Debit cards are accepted for initial premium payment only.

☐ Check ☐ Money Order ☐ Automatic Bank Draft *(attach voided check)*

☐ Credit Card Type: ☐ Visa ☐ MasterCard ☐ Debit Card Type: ☐ Visa ☐ MasterCard

Credit/Debit Card No.: _____ Exp. Date: _____/_____

Cardholder Name: _____

H. Applicant's 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.

Signature: _____ Date: _____/_____/_____

I. Broker/General Agent Signature

Signature of Preparer: _____ Date: _____/_____/_____ NJ Producer License #: _____

Print Agent Name: _____ Opportunity ID# _____

General Agent/Broker: _____ Agent/Vendor ID#_____

Instructions

INSTRUCTIONS AND ELIGIBILITY REQUIREMENTS

Instructions

- Except for section F, you must complete sections A through I, and sign and date this form, as well as any additional pages you may need to submit with it to provide further requested information.
- Please PRINT except when a signature is requested.
- For Section A-Type of Activity:
  - ➢ If you are applying to add a spouse, civil union partner, domestic partner, or child, use the "Add" section and check the applicable box. If the member being added is due to a triggering event, also use the "Other Change" section, check the box "Special Enrollment Period" and check the applicable reason.
  - ➢ If you are applying due to a triggering event that resulted in a Special Enrollment Period, use the "Other Change" section, check the box "Special Enrollment Period", check the applicable reason and attach proof.
    - Loss of eligibility for minimum essential coverage but not if lost due to non-payment of premium.
    - Dependent attained age 26 or 31 and lost coverage.
    - New dependent due to marriage, birth, adoption or placement for adoption, placement in foster care.
    - Access to a new plan due to a permanent move to New Jersey.
    - Marketplace changed your subsidy determination
    - Marketplace determination - error in enrollment or denial
  - ➢ If a dependent child is disabled and you want to continue his or her coverage beyond age 26, use the "Other Change" section, check the box "Other", describe the reason and attach proof of disability.
- You can obtain the providers' correct names and addresses from the appropriate provider directory. You may also obtain each provider's NPI number and LOC Code from the appropriate provider directory or at **www.HorizonBlue.com**. Providers with multiple office locations and individual providers who belong to more than one practice or provider entity may have more than one NPI number. You should confirm the correct NPI number for the specific provider and office location where you will be seen by contacting that office directly.
- For provider addresses, include the zip code plus the four-digit extension (9 digits).
- IF YOU HAVE ANY QUESTIONS concerning the benefits and services provided by or excluded under this policy, contact a Horizon Blue Cross Blue Shield of New Jersey Sales Representative at **1-888-425-5611** or your broker before signing this form.
- MAKE A COPY OF THIS COMPLETED APPLICATION! A copy of this application may be used as a temporary ID card for 30 days from the effective date if authorized by Horizon BCBSNJ. Coverage must be verified with Horizon BCBSNJ prior to visiting with a physician or admission to a hospital.

Eligibility

A. Eligibility requirements are set forth under the Individual Health Coverage Reform Act of 1992, P.L. 1992, c. 161 (N.J.S.A. 17B: 27A-2 et seq.).

B. You MUST be a New Jersey resident which means your primary residence is in New Jersey.

C. You must NOT be eligible for Medicare.

D. If application is made for the Horizon Advantage EPO Essentials Plan the following additional requirements apply:
1. You must be under 30 years old, or
2. You must have a Certificate of Exemption from the Marketplace. Attach a copy to your application.

E. **The Annual Open Enrollment Period** for coverage to be effective in 2015 runs from November 15, 2014 through February 15, 2015. Your application must be received during this time period. During this Annual Open Enrollment Period you may apply for or change coverage for yourself and family members who are currently uninsured or who are covered under another individual plan, or who are covered under a group health plan, group health benefits plan, a governmental plan or a church plan. The effective date of coverage applied for by December 31, 2014 will be January 1, 2015. The effective date of coverage applied for from January 1, 2015 through February 15, 2015 will be the first or fifteenth of the month following receipt of the application.

F. **A Special Enrollment Period** that lasts for 60 days follows the Triggering Events listed above. The effective date of a new policy will be no later than the first or fifteenth of the month following receipt of the application.

G. NOTE: If you currently have coverage the plan for which you are applying must REPLACE the current coverage but you SHOULD NOT terminate it until the new coverage is effective.

CONDITIONS OF ENROLLMENT - APPLICANT ACKNOWLEDGMENT AND AGREEMENTS

On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer reporting agency, and any employer to give Horizon BCBSNJ, or any consumer reporting agency acting on behalf of Horizon BCBSNJ, information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request Form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that Horizon BCBSNJ has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one.
4. I agree Horizon BCBSNJ will provide coverage in accordance with the terms of the contract for the individual plan.
5. I understand that my enrollment and the enrollment of my listed dependents in Horizon BCBSNJ's individual plan is conditioned upon acceptance by Horizon BCBSNJ.
6. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the individual policy if premiums are not paid timely.

Misrepresentations

Any person who includes any false or misleading information on a Nongroup Enrollment/Change Request Form for a health benefits plan is subject to criminal and civil penalties.