



Horizon Blue Cross Blue Shield of New Jersey

Dental Programs
P.O. Box 1938
Newark, NJ 07101-1938
www.HorizonBlue.com/dental
1-800-4DENTAL

Group Application for 51 + Employees

Group Number \_\_\_\_\_

Company Name: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Primary Location: \_\_\_\_\_
Street City State Zip

Telephone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_ SIC Code (4-Digit): \_\_\_\_\_

Type of Industry: \_\_\_\_\_ ID Cards Mailed to: [ ] Group [ ] Employee's Home

Company Official: Name \_\_\_\_\_ Title: \_\_\_\_\_ Phone#: \_\_\_\_\_

Billing Contact: Name \_\_\_\_\_ Title: \_\_\_\_\_ Phone#: \_\_\_\_\_

Number of Employees: Eligible \_\_\_\_\_ Enrolled in Plan \_\_\_\_\_

Employer Contribution: Employee \_\_\_\_\_ H/W \_\_\_\_\_ DP \_\_\_\_\_ Family \_\_\_\_\_ P/C \_\_\_\_\_

Dependent Child(ren) covered to age: \_\_\_\_\_ (eom/eoy) Full-time Students covered to age: \_\_\_\_\_ (eom/eoy)

Probationary Period and Effective Date:

New Hires: Date of Hire \_\_\_\_\_ # of Months \_\_\_\_\_ Effective Date [ ] 1st of month following
[ ] Exact Date
[ ] Other \_\_\_\_\_

Rehires: Date of Hire \_\_\_\_\_ [ ] Same as New [ ] Other \_\_\_\_\_

Termination of Employee: [ ] Exact Date [ ] End of Month

Class of Eligible Employees: (Check all that apply.)

[ ] Full Time/# Hours per week \_\_\_\_\_ [ ] Permanent Part Time/# hours per Week \_\_\_\_\_
Salaried \_\_\_\_\_ and/or Hourly \_\_\_\_\_

Union Affiliation: [ ] Yes, Local # \_\_\_\_\_ [ ] No

Current Carrier Replaced: \_\_\_\_\_

1. Is Horizon BCBSNJ's Internet maintenance for enrollment of interest to you?: [ ] Yes [ ] No

2. If yes, please provide email address for Internet contract: \_\_\_\_\_

3. Who will administer COBRA?: [ ] Group [ ] COBRA Elect [ ] Other \_\_\_\_\_

4. Are retirees eligible for dental benefits?: [ ] Yes Required minimum number of years worked: \_\_\_\_\_ [ ] No

5. Amount of advanced check, if any: \$ \_\_\_\_\_ Check #: \_\_\_\_\_

6. Is group in-force with HBCBSNJ for medical?: [ ] Yes [ ] No Group # \_\_\_\_\_

If yes, please provide the following information as it relates to the medical Plan:

Dependents covered to age: \_\_\_\_\_ (eom/eoy) Full-time students covered to age: \_\_\_\_\_ (eom/eoy)

**Agent/Producer Information** (This information must be answered completely.)

Broker Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Vendor Number: \_\_\_\_\_

Broker Name: \_\_\_\_\_ Name of Agency: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Others: Name \_\_\_\_\_ Title \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Company Official's Signature \_\_\_\_\_ Date \_\_\_\_\_

I authorize the aforementioned Commissioned Broker to be the Broker of Record for our health insurance. This contract will be valid until Horizon Blue Cross Blue Shield of New Jersey is notified in writing to cancel. Commissions should be paid to our company's Broker of Record beginning on our effective/anniversary date.