Horizon

Horizon Blue Cross Blue Shield of New Jersey

P.O. Box 1279
Newark, NJ 07101-1279
1-800-4DENTAL
www.HorizonBlue.com

HORIZON CENTURION DENTAL PROGRAM
APPLICATION FOR ENROLLMENT

Name _____
Last First Middle Initial

Address _____
Street City State Zip

Home Phone _____ Work Phone _____
Area Code Area Code

ELIGIBLE PERSONS TO BE ENROLLED

Complete this box for yourself and all dependents enrolling. Attach another application if you have more than four children.
(**Note:** Dependent children are covered under a parent's contract only until they reach the contract termination age of 23.)

LAST NAME	FIRST	MI	DATE OF BIRTH MO	DAY	YR	SEX M/F	SOCIAL SECURITY NUMBER
Applicant							
Spouse/Partner *(Circle One)*							
Child							
Child							
Child							
Child							
Legal Ward							

Enroll today in the Horizon Centurion Dental Program.
Please total the amount due

1 Individual at $60.00 Per = $ _____ Per Year
or
1 Family at $84.00 Total = $ _____ Per Year
2 Adults
or
Adult(s) & Dependent Child(ren)
See Terms and Limitations

Total Amount Due = $ _____ Per Year

☐ Payment enclosed.
Make check or money order payable to
Horizon Healthcare Dental Services, Inc.
☐ VISA ☐ MasterCard
Card number _____
Expiration date _____
Name on card _____

For Office Use Only - Broker Number

I hereby apply for participation. I understand and agree that any benefits provided pursuant to this application will be at the level of discounts indicated. I hereby accept responsibility for payment of the discounted charges. I understand that services must be provided by a Horizon Dental PPO dentist in order to receive any discount. **We reserve the right to change fees once per contract year with 30 days notice. I further acknowledge that dentist's fees under the Horizon Centurion Dental Program are subject to change and, that I will be responsible for the fees in effect at the time of service.** I further acknowledge that participation shall become effective only if approved and services are rendered on or after the effective date of participation which will be the first of the next month provided payment is received by the 15th of the current month. I certify to the best of my knowledge and believe the information given on this application is complete and true. I understand that my participation may be cancelled without written prior notice if I have included false information. I also understand that such termination will be retroactive to the date of my participation.

Signature _____ Date _____

1636 (W0307)

WHITE COPY - HBCBSNJ DENTAL PROGRAMS **YELLOW COPY - APPLICANT/SPONSOR**

HORIZON CENTURION TERMS AND LIMITATIONS

1. Eligible dependents under a family program include the participant's spouse/domestic partner and/or one or more of the participant's eligible child dependents. Eligible child dependents include natural born children or stepchildren of the participant or the participant's spouse/domestic partner, legally adopted children of the participant or the participant's spouse/domestic partner, a child for whom the participant or the participant's spouse/domestic partner has legal guardianship over and who is wholly dependent upon the participant or the participant's spouse/domestic partner for most of his/her support and maintenance, and the participant or the participant's spouse/domestic partner's foster children. Proof of support or adoption and all other matters pertaining to eligibility as a child dependent must be submitted to Horizon Blue Cross Blue Shield of New Jersey Dental Programs when requested.

2. Eligible child dependents are covered through the end of the month in which they turn age 23.

3. A child otherwise defined above but who has obtained age 23 and who Horizon Blue Cross Blue Shield of New Jersey Dental Programs determines is incapable of self-sustaining employment by reason of mental or physical handicap or developmental disability shall be considered a child under this program if he/she depends on the participant or the participant's spouse/domestic partner for support and maintenance and had the condition before attaining age 23. Proof of handicap must be submitted to Horizon Blue Cross Blue Shield of New Jersey Dental Programs when requested.

4. Payment for the Horizon Centurion program is made on an annual basis. No mid term refunds or adjustments (i.e., family to single) will be allowed.

5. Negotiated charge levels are only available when services are rendered by a Horizon Blue Cross Blue Shield of New Jersey Dental Programs participating PPO dentist.

6. The negotiated charge levels are subject to change in the future. Changes will occur no more than once during any twelve month period and participants will be notified 30 days in advance of any changes.

7. Services for which Horizon Blue Cross Blue Shield of New Jersey Dental Programs has not negotiated a discounted charge with the PPO dentists may be billed at the Dentists usual charge.

8. No person, other than the participant and his/her eligible dependents is entitled to receive the negotiated charges under this program. This program is not transferable.

9. This program provides discounted charges for most Dental services when the participant uses a Horizon Dental PPO provider. The participant is responsible for paying all discounted charges. No payments will be made by Horizon Blue Cross Blue Shield of New Jersey Dental Programs for services rendered under this program.