Updated: November 2023

Horizon
Horizon Blue Cross Blue Shield of New Jersey

ENROLLMENT/CHANGE REQUEST

Horizon Blue Cross Blue Shield of New Jersey

Attn: Large and Mid-Size Group Enrollment
Horizon Blue Cross Blue Shield of NJ
PO BOX 10168
Newark, NJ 07101-3168

Group Information - To Be Completed by Employer

Group Name	Group Number	Subgroup Number
County of Union	0866__	

A. Type of Activity - To Be Completed by Employer *Refer to instructions on back before completing this form. Print clearly.*

1. Enrollment
☐ New Subscriber
Effective Date
_____/_____/_____
Date of Hire
_____/_____/_____

2. Change - *Check all that apply.* **Date of Event** **Reason**
☐ Add Spouse/Domestic Partner ___/___/___ _____
☐ Add Dependent Child ___/___/___ _____
☐ Name Change ___/___/___ _____
☐ Change Plan ___/___/___ _____
☐ Other ___/___/___ _____
☐ Add/Change Office ID Numbers: Primary Care Physician/Ob/Gyn

3. Remove or Terminate - *Check all that apply.*
Effective Date **Reason**
☐ Remove Spouse/Domestic Partner* ___/___/___ _____
☐ Remove Dependent Child* ___/___/___ _____
☐ Employee Withdrawal/Termination ____/____/____
NOTE: Employee must be enrolled for spouse/dependent(s) to have coverage.
*Please complete *Add/Change/Remove* and *Name* columns in Section D.

4. Continuation of Coverage, i.e., COBRA, State, total disability
Not all options are available. Contact Employer for available options.
Coverage For: ☐ Employee ☐ Dependents
Length of Continuation: ☐ 12 mos ☐ 18 mos ☐ 29 mos ☐ 36 mos ☐ Total Disability*
Date of Loss of Coverage: ____/____/____
Date of Qualifying Event: ____/____/____
**Attach proof of total disability*

B. Employee Information - Please Complete Sections B - G

Social Security Number	Last Name, First Name, M.I.		Home Telephone ( )
Home Address	Apt.	City, State	ZIP Code
Employer Name			Work Telephone ( )
Work Address		City, State	ZIP Code

Date of employment_____/_____/_____ Hours worked per week _____

C. Plan Option - Select coverage tier and plan option.

Coverage Tiers
☐ Single
☐ 2 Adults
☐ Parent/Child(ren)
☐ Family

Medical Plans
☐ Direct Access #1 - 086676
☐ Direct Access #3 - 086677
☐ PPO - 086678
☐ EPO - 086681
☐ HSA - 086682

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children.

	(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex M F	Birthdate MM DD YYYY	Social Security Number	Other Health Coverage	Other Rx Drug Coverage	Primary Care Office ID Number	Current Patient	Previous Coverage
Employee			☐ ☐	/ /		Yes ☐	Yes ☐		Yes ☐	Yes ☐
Spouse			☐ ☐	/ /		☐	☐		☐	☐
Domestic Partner			☐ ☐	/ /		☐	☐		☐	☐
Child			☐ ☐	/ /		☐	☐		☐	☐
Child			☐ ☐	/ /		☐	☐		☐	☐
Child			☐ ☐	/ /		☐	☐		☐	☐

E. Other/Previous Insurance

Is Your Spouse/Domestic Partner Employed? ☐ Yes ☐ No If Yes, give name & address of spouse's/domestic partner's employer.

If "Yes" to Other Health Coverage (Section D), give name & policy number of insurance carrier, HMO, or other source.
If enrolled in Medicare Parts A and/or B, identify the coverage and provide the Medicare ID#.

If "Yes" to Other Rx Drug Coverage (Section D), give name & policy number of insurance carrier, HMO, or other source.

If "Yes" to Previous Coverage, identify name(s) of persons, give effective date and date coverage terminated, name of previous carrier and plan ID number.

F. Dependent Information

Does any dependent listed in Section D live at a different address than the Applicant? ☐ Yes ☐ No If "Yes," who and what address?

Explain the circumstances.

If any dependent's last name differs from yours, explain the circumstances.

G. Employee Signature

If you have any questions concerning the benefits and services provided by or excluded under this contract, contact a benefits representative at your company before signing this form.

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions on the reverse side of this enrollment/change request. I authorize deductions from my earnings for any required contributions.

Employee Signature - *Required*
X
Date / /
E-Mail Address

H. Employer Verification - To Be Completed by Employer

Employer Signature - *Required*
X
Title
Date / /

Employee copy may be used as a temporary ID card for 30 days from the effective date if authorized by employer. Coverage must be verified with Horizon BCBSNJ or Horizon Healthcare of New Jersey, Inc. prior to visiting a physician or admission to a hospital.

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