



# ENROLLMENT/CHANGE REQUEST

Horizon Blue Cross Blue Shield of New Jersey

Attn: Small Group Enrollment  
Horizon Blue Cross Blue Shield of NJ  
PO Box 607, Dept. A  
Newark, NJ 07101-0607  
www.horizonblue.com

## Group Information - To Be Completed by Employer

Group Name: \_\_\_\_\_ Group Number: \_\_\_\_\_ Subgroup Number: \_\_\_\_\_

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

<b>1. Enrollment</b> <input type="checkbox"/> New Subscriber Effective Date: ____/____/____	<b>2. Change - Check all that apply.</b> <input type="checkbox"/> Add Spouse/Domestic Partner <input type="checkbox"/> Add Dependent Child <input type="checkbox"/> Name Change <input type="checkbox"/> Change Plan <input type="checkbox"/> Other <input type="checkbox"/> Add/Change Office ID Numbers: Primary Care Physician/OB/GYN	<b>3. Remove or Terminate - Check all that apply.</b> <input type="checkbox"/> Remove Spouse/Domestic Partner <input type="checkbox"/> Remove Dependent Child <input type="checkbox"/> 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.	<b>4. Continuation of Coverage, i.e., COBRA, State, Total Disability</b> Not all options are available. Contact Employer for available options. Coverage For: <input type="checkbox"/> Employee <input type="checkbox"/> Dependents Length of Continuation: <input type="checkbox"/> 12 mos <input type="checkbox"/> 18 mos <input type="checkbox"/> 29 mos <input type="checkbox"/> 36 mos <input type="checkbox"/> Total Disability* Date of Loss of Coverage: ____/____/____ Date of Qualifying Event: ____/____/____ *Attach proof of total disability
---	--	---	--

**B. Employee Information - Complete Sections B - H**

Social Security Number: \_\_\_\_\_ Last Name, First Name, MI: \_\_\_\_\_ 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 - Your selection must be offered by your employer.**

Medical Check One:  S  F  HW (or DP)  P/C  
 Dental Check One:  S  F  HW (or DP)  P/C  
 Prescription Check One:  S  F  HW (or DP)  P/C  
 Horizon Traditional  
 Horizon HMO  
 Horizon POS  
 Horizon Direct Access  
 Horizon PPO  
 Prescription  
 Other \_\_\_\_\_

**D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. Attach proof if full-time college student.**

(Add/Change/Remove)	Last Name, First Name, MI	Sex M F	Birthdate MM DD YYYY	Social Security Number	Other Health Coverage Yes <input type="checkbox"/> No <input type="checkbox"/>	Primary Care ID Number	Current Patient Yes <input type="checkbox"/> No <input type="checkbox"/>	Previous Coverage Yes <input type="checkbox"/> No <input type="checkbox"/>
Employee		<input type="checkbox"/>	/ / /					
Spouse		<input type="checkbox"/>	/ / /					
Domestic Partner		<input type="checkbox"/>	/ / /					
Child		<input type="checkbox"/>	/ / /					
Child		<input type="checkbox"/>	/ / /					
Child		<input type="checkbox"/>	/ / /					

**F. Other/Previous Insurance**

Is your spouse or domestic partner employed?  Yes  No If "Yes," give name & address of spouse's or domestic partner's employer.

If "Yes" to Other Health Coverage (Section D), give name and 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 number.

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

**G. Dependent Information**

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

Explain the circumstances.

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

**E. Pre-Existing Conditions Statement**

NOTE: This information may ONLY be used to determine if a condition is a pre-existing condition. You CANNOT be denied coverage under a health benefit plan on the basis of accurate responses to the following questions. Carriers can only use the information to exclude the preexisting condition.

Yes/No 1. During the past 6 months have you or any dependent to be covered had or been diagnosed as having any of the following? If "Yes," check appropriate box(es) below.

a. Alcoholism or Drug Abuse  h. Heart Disorder or Condition or Chest Pain  
 b. Arthritis  i. High Blood Pressure  
 c. Blood Disorder  j. Kidney or Liver Disorder  
 d. Back or Neck Disorder  k. Lung or Respiratory Disorder  
 e. Cancer or Tumors  l. Mental or Nervous Disorder  
 f. Diabetes  m. Paralysis, Stroke or Epilepsy  
 g. Gastro or Intestinal Disorder

Yes/No 2. During the past 6 months, have you or any dependent to be covered:  
 a. been examined or treated by a physician or other health care provider for any condition, illness or injury, other than as stated above?  
 b. been advised to have treatment or surgery or testing that has not been done?  
 c. been admitted to a hospital or other health care facility as an inpatient?  
 d. taken prescribed medications?

Please give details for "Yes" answers to any part of Questions 1 or 2 on a separate sheet of paper. This separate sheet should be signed and dated.

**H. Employee Signature**

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

Employee Signature - Required: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employee Signature - Required: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**I. Employer Verification - To Be Completed by Employer**

Employer Signature - Required: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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. Services and products may be provided by Horizon Blue Cross Blue Shield of New Jersey, Inc., each of which is an independent licensee of the Blue Cross and Blue Shield Association. NJ-HHTT 6903 (W0804)