Horizon Blue Cross Blue Shield of New Jersey
P.O. Box 10168
Newark, New Jersey 07101-3168

STOP
RFHB

Check which plan you choose:
Direct Access_____ HSA____
EPO_____ Omnia_____

# APPLICATION FOR ENROLLMENT OR CHANGE

## SUBSCRIBER INFORMATION

| EMPLOYEE'S LAST NAME | FIRST | MI | PHONE-WORK ( ) / HOME ( ) FOR HORIZON BLUE CROSS BLUE SHIELD USE ONLY | EMPLOYEE NUMBER |
|---|---|---|---|---|
| ADDRESS-STREET | CITY, STATE | | ZIP | WORKING STATUS ☒ Active ☐ Retired |
| EMPLOYER NAME AND LOCATION (CITY AND STATE) Wayne Township Public Schools | Wayne, NJ | | | DATE OF HIRE |

**COVERAGE REQUESTED**
MEDICAL X
HEALTH PACKAGE ☐S ☐F ☐HW ☐PC
PRESCRIPTION ☐S ☐F ☐HW ☐PC
DENTAL (TRAD.) ☐S ☐F ☐HW ☐P

INDICATE WHETHER YOU AND/OR YOUR DEPENDENTS, IF ANY, ARE ENROLLED UNDER PART A AND/OR PART B OF MEDICARE.
APPLICANT: Part ☐A ☐B ID #: _____
DEPENDENT: Part ☐A ☐B ID #: _____
NAME: _____

IF DEPENDENT RESIDES AT ADDRESS OTHER THAN EMPLOYEE PLEASE NOTE NAME AND ADDRESS HERE

MARITAL STATUS
☐ SINGLE
☐ WIDOWED
☐ DIVORCED
☐ MARRIED
☐ SEPARATED

## 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 contract termination age as specified in the group contract.**

| | FIRST | MI | SEX | BIRTHDATE | SOC. SEC. NO. | HBCBSNJ ID (if applicable) |
|---|---|---|---|---|---|---|
| SELF - LAST NAME | | | ☐ Male ☐ Female | | | |
| SPOUSE - LAST NAME | | | ☐ Male ☐ Female | | | |
| CHILD - LAST NAME | | | ☐ Male ☐ Female | | | |
| CHILD - LAST NAME | | | ☐ Male ☐ Female | | | |
| CHILD - LAST NAME | | | ☐ Male ☐ Female | | | |
| LEGAL WARD - LAST NAME | | | ☐ Male ☐ Female | | | |

## COORDINATION OF BENEFITS: OTHER HEALTH INSURANCE

**Are you or any member of your family covered by another group health program? ☐ Yes ☐ No If so, please complete the required information below:**

| A. NAME OF POLICY HOLDER (Last, First) | B. POLICY OR IDENTIFICATION NUMBER | C. NAME OF OTHER INSURANCE COMPANY |
|---|---|---|
| D. ADDRESS OF OTHER INSURANCE COMPANY | E. NAME AND LOCATION (City, State) OF SPOUSE'S EMPLOYER | |

## FOR PRESENTLY ENROLLED CUSTOMERS CHANGING THEIR COVERAGE

**CHECK REASON(S) FOR CHANGE AND INDICATE THE DATE OF THE EVENT AND ID NUMBER.**

**A. ADDING DEPENDENT(S)** (BE SURE TO COMPLETE ELIGIBLE PERSONS TO BE ENROLLED)

☐ MARRIAGE ☐ LEGAL WARD ☐ SPOUSE'S COVERAGE TERMINATED ☐ BIRTH ☐ ADOPTION ☒ PREVIOUSLY REFUSED/WAIVED COVERAGE ☐ OTHER (Specify) _____

**B. DELETING DEPENDENT(S)**

☐ DIVORCE/SEPARATION ☐ COVERAGE ELSEWHERE ☐ CHILD REACHED TERMINATION AGE OR MARRIED ☐ DEATH ☐ MEDICARE ☐ ENTERED MILITARY ☐ OTHER (Specify) _____

NAME OF DEPENDENTS BEING DELETED
☐ SPOUSE ☐ CHILD(REN) _____

**C. CONTINUING COVERAGE UNDER COBRA**

☐ SPOUSE OF DECEASED EMPLOYEE ☐ EMPLOYMENT TERMINATED ☐ DIVORCE ☐ DISABLED ☐ REDUCTION IN HOURS/NO LONGER MEETS GROUP'S ELIGIBILITY REQUIREMENTS

☐ DEPENDENT CHILD NO LONGER ELIGIBLE UNDER TERMS OF EMPLOYER'S HEALTH PLAN ☐ COVERED DEPENDENT/EMPLOYEE BECOMING ELIGIBLE FOR MEDICARE

☐ OTHER (Specify) _____

**DATE OF EVENT** _____ / _____ / _____ **IDENTIFICATION NO. (Copy from your ID card)** _____

Effective Date of Coverage

## DISCLOSURE

Different providers in our network have agreed to be paid in different ways by us. Your provider may be paid each time he/she treats you (fee-for-service) or may be paid a set fee each month for each member whether or not the member actually receives services (capitation), or may receive a salary. These payment methods may include financial incentive agreements to pay some providers more (bonuses) or less (withholds), based on many factors: member satisfaction, quality of care, and control of costs and use of services among them. If you desire additional information about how our primary care physicians or any other providers in our network are compensated, please call us at 1-800-355-2583 or write "Horizon BCBSNJ, 3 Penn Plaza East, Newark, NJ 07105". The laws of the State of New Jersey at N.J.S.A.45:9-22.4 et seq., mandate that a physician, chiropractor or podiatrist who is permitted to make referrals to other health care providers in which s/he has a significant financial interest inform his or her patients of any significant financial interest he or she may have in a health care provider or facility when making a referral to that health care provider or facility. If you want more information about this, contact your physician, chiropractor or podiatrist. If you believe that you are not receiving the information to which you are entitled, contact the Division of Consumer Affairs in the New Jersey Department of Law and Public Safety at (973) 504-6200 OR (800) 242-5846.

## SIGNATURE

I hereby apply for the Horizon BCBSNJ coverage for me and my eligible dependents who are listed on this application. I understand and agree that our coverage will be controlled by the written agreement between Horizon BCBSNJ and my employer. I authorize my employer to make deductions from my earnings, if required, for my Horizon BCBSNJ coverage. The undersigned hereby authorizes any health care facility or provider to release to Horizon BCBSNJ all information relating to health care examinations or treatments received during the six months prior to the effective date of coverage or for present or future health care examinations or treatments received by each person covered by this application. I understand Horizon BCBSNJ will collect this information solely for the purposes of determining whether coverage is to be provided or providing benefits under my coverage and this authorization is expressly limited to information reasonably necessary for such purposes. This authorization will terminate with respect to each covered person upon termination of coverage, except as necessary to finalize payment of claims for such person following termination of coverage. I recognize that our coverage will only apply to hospital admissions which occur and services or supplies which are provided on or after the effective date of our coverage. I understand that eligible benefits must be provided or arranged through each member's primary care physician of record and authorized, when required, by Horizon BCBSNJ. I realize that in selecting Horizon BCBSNJ, I cannot change my health coverage until my group's next annual open enrollment period, even if my primary care physician is no longer available to provide services. The only exception to this is if I move my residence outside of the Horizon BCBSNJ service area. I understand that any person who knowingly includes any false or misleading information on an application for insurance is subject to criminal and civil penalties. I understand that any claim by me or one of my eligible dependents may be denied and our coverage cancelled and terminated without prior written notice if I have knowingly included material false information in this application. I also understand that such a termination may be retroactive to the effective date of our coverage. In the event of such a termination, if Horizon BCBSNJ advances payment to any provider for covered services, the undersigned will return any reimbursement for these prepaid services to Horizon BCBSNJ.

Signature of Applicant _____ Date _____

## REASON FOR APPLICATION

☐ New Hire ☐ Open Enrollment
☐ Rehire ☐ Newly Eligible ☐ Cobra
☐ Adding/Deleting Dependents
☐ HMO Open Enrollment HMO Name _____
☐ Other _____

## EMPLOYER USE ONLY

| GROUP NAME Wayne Twsp Public Schools | GROUP NO. 085478- | |
|---|---|---|
| PROPOSED EFFECTIVE DATE | PAYROLL LOCATION (if applicable) | EMPLOYEE NO. (if applicable) |
| REMITTING AGENT'S SIGNATURE AND DATE | | |

## FOR PLAN USE ONLY

| |
|---|
| INPUT DATE/INITIAL |
| VERIFY DATE/INITIAL |
| HEALTH PACKAGE |
| Rx |
| DENTAL |

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HORIZON BCBS NJ COPY