FAX TO PRINCETON HR: 866-625-6856

Horizon Blue Cross Blue Shield of New Jersey

NON-GROUP ENROLLMENT/CHANGE REQUEST

Mail to: Horizon BCBSNJ
Attn: Consumer Enrollment Dept.
P.O. Box 1330
Newark, NJ 07101-1330
Email to: individualapplication@**HorizonBlue.com**
Fax to: 973-274-4413
HorizonBlue.com

A. Type of Activity – to be completed by Applicant

Refer to instructions before completing this form. (Check all that apply)

1. ADD

	Date of Event	Reason		Date of Event	Reason
☐ Enrollment of a new Subscriber	____/____/____	_____	☐ Add Domestic Partner	____/____/____	_____
☐ Add Spouse	____/____/____	_____	☐ Add Dependent Child	____/____/____	_____
☐ Add Civil Union Partner	____/____/____	_____			

2. REMOVE

	Date of Event	Reason		Date of Event	Reason
☐ Remove Spouse	____/____/____	_____	☐ Remove Domestic Partner	____/____/____	_____
☐ Remove Civil Union Partner	____/____/____	_____	☐ Remove Dependent Child	____/____/____	_____

3. OTHER CHANGE

	Date of Event	Reason		Date of Event	Reason
☐ Name Change	____/____/____	_____	☐ Add/Change Office ID Numbers: Primary Care Provider	____/____/____	_____
☐ Change Plan	____/____/____	_____			
☐ Special Enrollment Period (Check triggering event below and attach proof)	____/____/____		☐ Other	____/____/____	_____

- ☐ Loss of minimum essential coverage
- ☐ Dependent attained age 26 or 31 and lost coverage
- ☐ Marriage
- ☐ Birth/adoption/foster care
- ☐ Child support order or other court order
- ☐ Access to new plan due to permanent move
- ☐ Marketplace changed subsidy determination
- ☐ NJ FamilyCare denial
- ☐ Domestic abuse or spousal abandonment

B. Applicant Information

◯ Add ◯ Other Change ◯ Continue *If a name change, indicate prior name:* _____

Last Name: | First Name: | MI:

Social Security #: | Date of Birth: MM DD YYYY | Sex: ◯ M ◯ F

Email:

Are you a resident of New Jersey? ◯ Yes ◯ No

Primary Residence: Street | Apt.:

City: | State: | Zip Code + 4: — | Phone:

Do you maintain a home in any other state/country? ◯ Yes ◯ No *If yes:* Name of state/country: _____ Number of months you live there each year: _____

Other Residence: Street | Apt.:

City: | State: | Zip Code + 4: — | Phone:

Your billing address: ◯ Primary residence ◯ Other residence ◯ P.O. Box or Other *(specify)*: _____

Are you eligible for Medicare? ◯ Yes ◯ No

Are you covered under Medicare Part A or Part B? ◯ Yes ◯ No

Please note: If you are eligible for Medicare, the individual policy will coordinate as secondary payor to what Medicare paid or would have paid. Individual polices do not operate as Medicare supplement polices.

Are you covered under Other Health Coverage? ◯ Yes ◯ No

If yes, why are you applying for individual coverage and what is your intended termination date? _____

APPLICANT'S LAST NAME _____ FIRST NAME _____ MI _____

C. Plan Options **Please select desired medical plan option. We cannot issue you a medical plan without a pediatric dental plan.**

Medical *(check one)*

Horizon Advantage Plans We encourage you to select a Primary Care Provider (PCP) in Section F to maximize your benefits.

- ☐ Horizon Advantage EPO Silver
- ☐ Horizon Advantage EPO Bronze
- ☐ Horizon Advantage EPO Essentials. You must be under age 30 or provide a notice that you qualify for an exemption from the Marketplace if you are age 30 or older.

OMNIA Health Plans

- ☐ OMNIA Gold
- ☐ OMNIA Silver
- ☐ OMNIA Silver HSA
- ☐ OMNIA Bronze HSA

Medical Unit *(check one):* ☐ Single ☐ Family ☐ Two Adults ☐ Adult & Child(ren)

Pediatric Dental and Family Pediatric Dental *(required)*

Stand Alone Pediatric Dental (SAPD) Plan options: Federal law requires all ten categories of essential health benefits which includes pediatric dental benefits to be made available to you, whether or not you have dependents under age 19. Because the above medical plan options do not contain pediatric dental benefits, you must provide assurance that you have, or will obtain a Marketplace-certified SAPD plan. **We will automatically enroll you and your covered dependents in the Horizon Young Grins SAPD plan, unless you have Horizon Young Grins, Horizon Family Grins, Horizon Family Grins Plus or select one of the options below.**

☐ I want to purchase a family pediatric dental plan which provides Marketplace-certified SAPD coverage for individuals under age 19 plus dental coverage for covered persons age 19 and older instead of the Horizon Young Grins SAPD plan.

Plan *(check one):* ☐ Horizon Family Grins ☐ Horizon Family Grins Plus

☐ I have purchased a Marketplace-certified SAPD plan with another carrier. I agree to provide information demonstrating this coverage immediately to Horizon BCBSNJ if requested, that may include the evidence of coverage, the name of the issuer and applicable policy number. I attest that this information is accurate and agree to hold Horizon BCBSNJ harmless from any harm, monetary loss, or liability in connection with reliance on your representation.

APPLICANT'S LAST NAME _____ FIRST NAME _____ MI _____

D. Other Individuals Covered

Identify individuals other than yourself for whom you are adding/changing/removing coverage. Attach additional pages if necessary, dated and signed by you. Attach proof of disability.

1. SPOUSE/CIVIL UNION PARTNER/DOMESTIC PARTNER ○ Add ○ Remove ○ Other

Last Name (If last name is different from applicant's attach proof): First Name: MI:

Social Security #: Date of Birth: MM DD YYYY Sex: ○ M ○ F Home address same as applicant? ○ Yes ○ No

If no, provide home address and explain why the address is different: _____

Home Address: Street Apt.:

City: State: Zip Code + 4: —

Are you eligible for Medicare? ○ Yes ○ No

Are you covered under Medicare Part A or Part B? ○ Yes ○ No

Are you covered under Other Health Coverage? ○ Yes ○ No *If yes,* why are you applying for individual coverage and what is your termination date? _____

2. CHILD ○ Add ○ Remove ○ Other

Last Name (If last name is different from applicant's attach proof): First Name: MI:

Social Security #: Date of Birth: MM DD YYYY Sex: ○ M ○ F Living with applicant? ○ Yes ○ No **If No, complete Section E**

Are you eligible for Medicare? ○ Yes ○ No

Are you covered under Medicare Part A or Part B? ○ Yes ○ No

Are you covered under Other Health Coverage? ○ Yes ○ No *If yes,* why are you applying for individual coverage and what is your termination date? _____

3. CHILD ○ Add ○ Remove ○ Other

Last Name (If last name is different from applicant's attach proof): First Name: MI:

Social Security #: Date of Birth: MM DD YYYY Sex: ○ M ○ F Living with applicant? ○ Yes ○ No **If No, complete Section E**

Are you eligible for Medicare? ○ Yes ○ No

Are you covered under Medicare Part A or Part B? ○ Yes ○ No

Are you covered under Other Health Coverage? ○ Yes ○ No *If yes,* why are you applying for individual coverage and what is your termination date? _____

E. Additional Child Information

Provide information below about children listed in Section D, if they have a different address. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.

Name:

Address: Street Apt:

City: State: Zip Code + 4: —

Reason: _____

Name:

Address: Street Apt:

City: State: Zip Code + 4: —

Reason: _____

APPLICANT'S LAST NAME _____ FIRST NAME _____ MI _____

F. Horizon Advantage Plans Primary Care Provider (PCP) Selection - Selecting a PCP for you and each covered dependent is not required but will help maximize your benefits. Attach additional pages if necessary, signed and dated by you.

1. APPLICANT

Last Name: _____ First Name: _____ MI: _____

Primary Care Provider Name: _____ Current Patient: Yes: ○ No: ○

Primary Care Provider Address: _____

City: _____ State: _____ Zip Code +4: _____

NPI #: _____ Loc Code: _____

2. SPOUSE/CIVIL UNION PARTNER/DOMESTIC PARTNER

Last Name: _____ First Name: _____ MI: _____

Primary Care Provider Name: _____ Current Patient: Yes: ○ No: ○

Primary Care Provider Address: _____

City: _____ State: _____ Zip Code +4: _____

NPI #: _____ Loc Code: _____

3. CHILD

Last Name: _____ First Name: _____ MI: _____

Primary Care Provider Name: _____ Current Patient: Yes: ○ No: ○

Primary Care Provider Address: _____

City: _____ State: _____ Zip Code +4: _____

NPI #: _____ Loc Code: _____

4. CHILD

Last Name: _____ First Name: _____ MI: _____

Primary Care Provider Name: _____ Current Patient: Yes: ○ No: ○

Primary Care Provider Address: _____

City: _____ State: _____ Zip Code +4: _____

NPI #: _____ Loc Code: _____

G Race/Ethnicity *Your response is appreciated but NOT required. Choose a category that most closely describes you:*

○ American Indian or Alaskan Native ○ Black, not of Hispanic origin ○ Hispanic
○ Asian or Pacific Islander ○ White, not of Hispanic origin

H. Payment Information *Indicate how you would like to make payment.*

○ Check ○ Money Order ○ One time Automatic Bank Draft (used for initial premium payment only)

Provide Bank Information for Automatic Bank Draft: Routing # _____ Account # _____

○ Credit or Debit Card Type: ○ Visa ○ MasterCard

Credit or Debit Card No.: _____ Exp. Date: _____/_____

Cardholder Name: _____

I. Applicant's Signature

I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form.

Signature: _____ Date: _____/_____/_____

J. Broker/General Agent Signature

Signature of Preparer: _____ Date: _____/_____/_____ NPN#: 7547222

Print Agent Name: LISA KEITH

General Agent/Broker: _____ Agent/Vendor ID# _____