Horizon Blue Cross Blue Shield of New Jersey

P.O. BOX 10168
NEWARK, NEW JERSEY 07101-9786

IMPORTANT: READ INSTRUCTIONS AND ELIGIBILITY REQUIREMENTS PRIOR TO COMPLETING ATTACHED FORM

INSTRUCTIONS TO SUBSCRIBER

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

1. Read the ELIGIBILITY REQUIREMENTS below.
2. Provide the information requested in boxes 1 through 27 of PART I.
3. Read the conditions contained in PART I, sign and date where indicated.
4. Forward the form to the dependent's attending Practitioner TOGETHER with the enclosed return envelope.

INSTRUCTIONS TO THE PRACTITIONER

1. Provided all information requested in PART II. (on reverse side of application)
2. Forward the completed form to:

   HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY
   PO BOX 10168
   NEWARK, NEW JERSEY 07101-9786

CONDITIONS NECESSARY TO ESTABLISH ELIGIBILITY

1. The dependent is unmarried
2. The incapacitating condition started before the age specified policy age limit.
3. The dependent must have been insured before the age limit of the policy. If insured by another carrier before applying to Horizon BCBSNJ, documentation should be provided.
4. The application for continuation of enrollment must be filed within 31 days from the date the dependent reaches policy age limit.
5. The subscriber must provide proof of the dependent's incapacitation by submitting responses to the following questions at the time of application for continuation of enrollment.
6. Frequency for reassessment of continuation determined by dependent's condition and contract requirements.

Horizon Blue Cross Blue Shield of New Jersey

P.O. BOX 10168
NEWARK, NEW JERSEY 07101-9786

REQUEST FOR CONTINUANCE OF ENROLLMENT FOR A DISABLED DEPENDENT

Reset Form

Vision benefits are provided by Horizon Insurance Company. Medical and Dental benefits are provided by Horizon Healthcare Services, Inc.. Dental benefits (specifically, Horizon Dental Choice Plans and Horizon Total Care) are provided by Horizon Healthcare Dental, Inc.

You may complete the required fields below online and then save or print a copy for submission. To save a completed copy to your computer, choose File > Save As to rename the file and save the form with your information to your computer.

PART I - TO BE COMPLETED BY SUBSCRIBER

1. SUBSCRIBER'S NAME		2. TELEPHONE # ( ) -	
3. ADDRESS Street	City	State	ZIP
4. DEPENDENT'S NAME		5. RELATIONSHIP TO SUBSCRIBER	
6. DEPENDENT'S BIRTH DATE	7. DATE OF ONSET OF DISABILITY / HANDICAP		
8. NAME OF PRESENT INSURANCE CARRIER FOR DEPENDENT		9. ID # / POLICY #	
10. GROUP#	10a. GROUP NAME	11. COVERAGE START DATE	12. COVERAGE END DATE
13. Please indicate prior insurance carrier since onset of disability / handicap CARRIER NAME			14. ID # / POLICY #
15. GROUP #	16. COVERAGE START DATE	17. COVERAGE END DATE	*Attach any additional information on separate page*

18. WHY ARE YOU APPLYING FOR CONTINUATION OF BENEFITS FOR THE DEPENDENT AT THIS TIME?

19. CAN THE DEPENDENT PERFORM THE ACTIVITIES OF DAILY LIVING LISTED BELOW? (Check all that apply)

☐ Bathing ☐ Dressing ☐ Eating ☐ Toileting ☐ Transferring from to chair/bed

20. IS THE DEPENDENT ABLE TO:

☐ Move about Inependently ☐ Travel Independently ☐ Manage Finances

20a. IS DEPENDENT HOMEBOUND?

☐ YES ☐ NO

21. DOES THE DEPENDENT WORK FOR WAGES?

☐ YES If YES, give name of employer:

Weekly hours: Annual Salary:

☐ NO If NO, give reason(s) why unable to work:

21a. IF THE DEPENDENT IS NO LONGER WORKING OR HAS NEVER WORKED, PLEASE EXPLAIN WHY:

22. IS DEPENDENT ELIGIBLE FOR HEALTH COVERAGE THROUGH HIS, HER EMPLOYER? ☐ YES ☐ NO

23. IS DEPENDENT IN COLLEGE / SPECIAL SCHOOL OR CONFINED TO AN INSTITUTION?

☐ YES ☐ NO If YES, give name/location: Type of program or course of study:

(OVER)

24. DOES THE DEPENDENT RECEIVE OR HAS THE DEPENDENT EVER RECEIVED VOCATIONAL TRAINING DESIGNED TO INCREASE INDIVIDUAL FUNCTIONALITY?

If so name: If not, why not:

dates:

25. WHAT ARE THE SPECIFIC WAYS IN WHICH YOU SUPPORT OR MAINTAIN THE DEPENDENT?

26. HOW / WHAT TYPE OF CARE DO YOU PROVIDE FOR THE DEPENDENT?

27. HAS THE DEPENDENT APPLIED FOR SSI / MEDICARE / MEDICAID? (circle all applicable)
If not, why:

In accordance with amendments to the New Jersey laws governing health service corporations whereby the enrollment of mentally impaired and/or physically disabled children who attained termination age on and after August 10, 1966 may, under certain conditions, be continued under their parent's Horizon Blue Cross Blue Shield of New Jersey coverage beyond such termination age, I herewith request such continuation of enrollment on behalf of my child named above.

I UNDERSTAND AND AGREE that continuation of enrollment for the child named above, if approved, may remain in effect only as long as the mental impairment and/or physical disability and dependency exist, and so long as Horizon Blue Cross Blue Shield of New Jersey coverage, in my name or in the name of my spouse, if any, remains in force, with no greater than thirty day lapse between any changes in coverage, and provided that coverage is at all times of the type which includes such child. I FURTHER UNDERSTAND AND AGREE that the Plan shall have the right to require periodic recertification as to eligibility for continued extension of dependency coverage.

I represent that to the best of my knowledge and belief the information given above is correct, that the child named above meets the eligibility requirements as to unmarried status and enrollment under my coverage, and is dependent upon me for more than one-half of his(her) support and maintenance.

Subscriber's Name: _____ *Date:* _____

PART II - TO BE COMPLETED BY DEPENDENT'S ATTENDING PHYSICIAN

INSTRUCTIONS: ATTENDING PRACTITIONER MUST ANSWER ALL QUESTIONS. (Please print or type).

IN NOTE: IF THIS DOCUMENT IS ILLEGIBLE OR INCOMPLETE, IT WILL BE RETURNED.

If more information needs to be provided, please attach additional pages. Please forward complete form and any additional information to the subscriber.

Subscriber Name: _____

Questions to be answered by the dependent's Attending Practitioner: _____

(If disability is due to mental or psychiatric disorder, please have the appropriate behavioral health provider complete form).

1. DIAGNOSIS (ES) must PROVIDE NARRATIVE TEXT IN ADDITION TO ICD-10 or DSM 5 CODES:

DIAGNOSIS	NARRATIVE TEXT
1.	
2.	
3.	
4.	
5.	

(OVER)

2. If mentally impaired, define mental impairment in terms of mental age _____ IQ _____ or functional capacity in work, educational or social setting.
Please attach results or summary of most recent testing done to define dependent's functional level.

_____

3. If physically impaired, define physical impairment in terms of capacity to perform activities normally done by individuals of comparable age, intellectual capacity.

_____

4. Is the condition temporary or permanent? _____ Is the condition static or progressive? _____

5. Is the condition currently controlled with medical management?

If No, why not _____

If Yes, specify therapy_____

5a. Date of last Medical Exam: _____

6. If dependent is attending college, working, or in a training program, what makes this individual more reliant on parent support and maintenance than his/hers non disabled peers and thus make continuation of enrollment under parent's policy necessary.

_____

7. In your opinion, is the dependent able to work, attend school or a vocational training program?
Now: ☐ Yes ☐ No In the Future: ☐ Yes ☐ No

If no, why not? _____

8. If Behaviorally impaired, define the dependent's functional capacity, limitations and ability to perform work, educational and social activities normally done by individuals of comparable age:

- Is dependent able to understand or follow instruction? ☐ Yes ☐ No
- Does dependent's emotional state prevent him/her from concentrating on a task? ☐ Yes ☐ No
- Can dependent tolerate a work environment? ☐ Yes ☐ No
- Why could Dependant not work at home? ☐ Yes ☐ No

Please provide detailed explanation of behavioral health disabilities here:
MUST ALSO PROVIDE A SUMMARY OF MOST RECENT TESTING DONE TO DEFINE FUNCTIONAL LEVEL.

_____

_____

9. Is patient complying with treatment? ☐ Yes ☐ No

10. Describe the special supervisory, physical assistance or custodial care required by dependent.

_____

_____

11. If dependent's parents were suddenly no longer able to help, would the dependent be able to function independently or would he/she become a ward of social agency? Must explain:

_____

_____

(OVER)

I hereby certify that I am a practicing _____ duly licensed in the State of _____ and certify to the correctness of this information provided above.

Please print the following information	PRACTITIONER'S NAME
	PRACTITIONER'S ADDRESS

SIGNATURE OF PRACTITIONER	NPI NUMBER	PHONE # ( ) -	DATE SIGNED

PART III - TO BE COMPLETED BY PLAN

Continuation of enrollment of the dependent named above under his(her) parent's coverage (is) (is not) approved.
This certification applies to all coverages.

Authorized Signature: _____ Date: _____

Horizon Blue Cross Blue Shield of New Jersey

Three Penn Plaza East
Newark, NJ 07105-2200
HorizonBlue.com

Notice of Nondiscrimination

Horizon Blue Cross Blue Shield of New Jersey complies with applicable Federal civil rights laws and does not discriminate against nor does it exclude people or treat them differently on the basis of race, color, gender, national origin, age, disability, pregnancy, gender identity, sex, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations.

Horizon BCBSNJ provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information written in other languages.

Contacting Member Services
Please call Member Services at **1-800-355-BLUE (2583) (TTY/TDD 711) or the phone number on the back of your member ID card**, if you need the free aids and services noted above and for **all other Member Services issues, including:**

- **Claim, benefits or enrollment inquiries**
- **Lost/stolen ID cards**
- **Address changes**
- **Any other inquiry related to your benefits or health plan**

Filing a Section 1557 Grievance
If you believe that Horizon BCBSNJ has failed to provide the free communication aids and services or discriminated on the basis of race, color, gender, national origin, age or disability you can file a discrimination complaint also known as a Section 1557 Grievance. Horizon BCBSNJ's Civil Rights Coordinator can be reached by calling the Member Services number on the back of your member ID card or by writing to the following address:

Horizon BCBSNJ – Civil Rights Coordinator
PO Box 820
Newark, NJ 07101

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

Office for Civil Rights Headquarters
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019 or **1-800-537-7697** (TDD)

OCR Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

Horizon Blue Cross Blue Shield of New Jersey

If you need help understanding this Horizon Blue Cross Blue Shield of New Jersey information, you have the right to get help in your language at no cost to you. To talk to an interpreter, please call **1-800-355-BLUE (2583)** during normal business hours.

Spanish (Español): Si necesita ayuda para comprender esta información de Horizon Blue Cross Blue Shield of New Jersey, usted tiene el derecho de obtener ayuda en su idioma sin costo alguno. Para hablar con un intérprete, sírvase llamar al **1-855-477-AZUL (2985)** durante el horario normal de trabajo.

Chinese (中文)：如果您需要幫助來理解這份新澤西州地平線藍十字藍盾 (Horizon Blue Cross Blue Shield of New Jersey)資料，您有權免費獲得以您的語言提供的協助。欲聯絡翻譯人員，請於上班時間致電 **1-800-355-BLUE (2583)**。

Korean (한국어): 가입자는 Horizon Blue Cross Blue Shield of New Jersey에 관한 정보를 이해하기 위해 주로 사용하는 언어로 무료로 도움을 받을 권리가 있습니다. 통역사의 도움을 받으려면 정상 업무 시간 동안에 **1-800-355-BLUE (2583)**로 전화해 주십시오.

Portuguese (Português): Se precisar de ajuda para entender estas informações da Horizon Blue Cross Blue Shield of New Jersey, você tem o direito de receber gratuitamente assistência no seu idioma. Para falar com um intérprete, ligue para: **1-800-355-BLUE (2583)** no horário normal de trabalho.

Gujarati (ગુજરાતી): જો તમને આ ન્યુ જર્સી માહિતીનાં હોરાઈઝન્સ બ્લૂ ક્રોસ બ્લૂ શીલ્ડને સમજવા મદદની જરૂર હોય તો, તમને તમારી ભાષામાં કોઈ પણ ખર્ચ વગર મદદ મેળવવાનો અધિકાર છે. કોઈ દુભાષિયા સાથે વાત કરવા, કૃપા કરીને સામાન્ય બિઝનેસ કલાકો દરમિયાન **1-800-355-BLUE (2583)** પર ફોન કરો .

Polish (Polski): Jeżeli potrzebujesz pomocy, aby zrozumieć informacje planu Horizon Blue Cross Blue Shield of New Jersey, masz prawo poprosić o bezpłatną pomoc w języku ojczystym. Aby skorzystać z pomocy tłumacza, zadzwoń pod numer **1-800-355-BLUE (2583)** podczas normalnych godzin pracy.

Italian (Italiano): Se vi serve aiuto per capire queste informazioni della Horizon Blue Cross Blue Shield of New Jersey, avete diritto ad assistenza gratis nella vostra lingua. Per parlare con un interprete, siete pregati di telefonare al numero **1-800-355-BLUE (2583)** durante le normali ore d'ufficio.

Tagalog (Tagalog): Kung kailangan mo ng tulong sa pag-unawa nitong impormasyon ng Horizon Blue Cross Blue Shield of New Jersey, may karapatan kang humingi ng tulong sa iyong wika nang walang gastos sa iyo. Upang makipag-usap sa isang taga-interpret, mangyaring tumawag sa **1-800-355-BLUE (2583)** sa loob ng karaniwang mga oras ng negosyo.

Russian (Русский язык): Если вам необходима помощь в разъяснении этой информации, предоставленной компанией Horizon Blue Cross Blue Shield of New Jersey, у вас есть право на получение помощи на вашем родном языке бесплатно. Для связи с переводчиком звоните по номеру телефона **1-800-355-BLUE (2583)** в обычные рабочие часы.

Haitian Creole (Kreyòl ayisyen): Si ou bezwen èd pou konprann enfòmasyon sou Horizon Blue Cross Blue Shield of New Jersey, ou gen dwa pou jwenn èd nan lang natifnatal ou gratis. Pou pale avèk yon entèprèt, tanpri rele nimewo **1-800-355-BLUE (2583)** pandan lè nòmal biznis.

Hindi (हिंदी): यदि आपको न्यू जर्सी की इस होराइज़न ब्लू क्रॉस ब्लू शील्ड सूचना को समझने में सहायता की ज़रूरत है, तो आपके पास मुफ्त में अपनी भाषा में सहायता पाने का अधिकार है। किसी दुभाषिए से बात करने के लिए, कृपया सामान्य कार्य समय के दौरान **1-800-355-BLUE (2583)** पर कॉल करें।

Vietnamese (Tiếng Việt): Nếu cần được giúp đỡ để hiểu rõ thông tin này của Horizon Blue Cross Blue Shield of New Jersey, quý vị có quyền được giúp đỡ bằng ngôn ngữ của mình miễn phí. Xin gọi số **1-800-355-BLUE (2583)** trong giờ làm việc để nói chuyện với người thông dịch.

French (Français): Si vous avez besoin d’assistance pour comprendre ces informations au sujet de Horizon Blue Cross Blue Shield of New Jersey, vous avez le droit d’obtenir de l’aide dans votre langue, sans aucun frais. Pour parler avec un interprète, veuillez appeler le **1-800-355-BLUE (2583)** pendant les heures normales de bureau.

Navajo (Diné): Díí New Jersey bił hahoodzo Horizon Blue Cross Blue Shield, t’áá ninizaad k’ehjí baa hane’íí bik’i diitįįh bee shiká’ a’doowoł nínízingo éí bee ná’ahoot’i’ dóó doo bąąh ílíní da. Ata’ halne’é ła’ bich’į’ hadeesdzih nínízingo t’áá shǫǫdí **1-800-355-BLUE (2583)**jį’ nida’anishgo oolkiłíí bik’ehgo hodíílnih.

Arabic (عربي): إذا كنت بحاجة إلى المساعدة في فهم معلومات Horizon Blue Cross Blue Shield of New Jersey، لديك الحق في الحصول على المساعدة بلغتك دون تحملك أية تكلفة. للتكلم مع مترجم، يرجى الاتصال خلال ساعات العمل العادية بالرقم **1-800-355-BLUE (2583)**.

Urdu (**اردو**)**:** اگر آپ کو نیوجرسی انفارمیشن کے اس آسمانی نیلے رنگ والے تیز نیلے رنگ والے شیلڈ کو سمجھنے میں مدد کی ضرورت ہے تو، آپ کو اپنی زبان میں بغیر کسی خرچ کے مدد حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، براہ کرم، معمول کے کاروباری اوقات میں **1-800-355-BLUE (2583)** پر کال کریں۔