RESET

Horizon

APPLICATION FOR A SMALL GROUP HORIZON LEVEL SELECT HEALTH BENEFITS POLICY (15 to 50 eligible employees)

Please print or type Policy Number:_____ □ New Policy □ Change in Policy Requested Effective Date: _____

Note: The Effective Date will be on or after the date Horizon Blue Cross Blue Shield of New Jersey approves the application.

SECTION I: POLICYHOLDER INFORMATION

1. Policyholder (full legal name of company): _____

2. Tax Identification Number: _____

3. Main Address: _____
   Street City State ZIP

   Mailing Address: _____
   Street City State ZIP

   Telephone:_____ Facsimile:_____ Email Address: _____

   Correspondent:_____ Title: _____

   Summary Plan Document (SPD) should be provided: □ electronically or □ hard copy. Check one.

4. Type of Organization: □ Corporation □ Partnership □ Proprietorship □ Other (explain): _____

5. Nature of Business (specify):_____ SIC Code: _____

6. Number of full-time employees in your company: _____
   Refer to the Small Employer Certification for the definition of a full-time employee.

7. Number of full-time employees to be enrolled:_____ 8. Class or classes to be excluded: _____

9. Insurance Requested For:
   □ Employees Only □ Employees and Dependents including Spouse □ Employees and Dependents excluding Spouse

   Should the plan provide coverage for domestic partners as permitted by P.L. 2003, c. 246? □ Yes □ No
   If yes, should the plan provide coverage for coverage of children of a covered domestic partner? □ Yes □ No

10. Is the employer subject to the requirements of COBRA? □ Yes □ No

11. Is the employer subject to the requirements of Medicare as Secondary Payor Rules for eligibility due to age? □ Yes □ No
    Due to disability? □ Yes □ No

12. Orientation Period? □ Yes □ No

13. Waiting period before employees become enrolled: (may not exceed 90 days)
    Present Employees : □ no waiting period □ one month □ two months □ 90 days
    New or Rehired Employees: □ no waiting period □ one month □ two months □ 90 days

14. Period for Annual Employee Open Enrollment Period: _____

15. What percentage of the premium will the employer pay? _____

16. Deposit $ _____

Premium Paid: Automatic checking monthly withdrawal
The premium for the first month of coverage must be attached.

Affiliates, subsidiaries or branches (Must be included for purposes of participation)

Legal Name & Location	No. of full-time employees in this company	No. of full-time employees to be enrolled

SECTION II: SPECIFICATIONS FOR COVERAGE

HEALTH BENEFITS

Advantage Direct Access

□ 100/70 - $20/$40 copay, $10/$25/$50 Rx, with BlueCard

Advantage EPO

□ 100/80 - $20/$40 copay, $10/$25/$50 Rx, with BlueCard

□ 100/70 - $45/$70 copay, $25/$50/$75 Rx, with BlueCard

□ 100/70 - $45/$70 copay, $25/$50/$75 Rx

□ 50 – 50% after deductible, 50% after deductible Rx, without BlueCard

□ Catastrophic -100% after deductible

OMNIA

□ 100/70 - $10/$40/$75 Rx
□ 100/50 - $20/50%/50%, 50% after Tier 1 Rx deductible
□ Value 60/50 - $10/$40/$75 Rx after Tier 1 deductible
□ 50 – 50% Rx after Tier 1 deductible, without BlueCard

HSA plan

□ OMNIA 80/50 - 60% Rx after Tier 1 deductible, with BlueCard

SECTION III: ALL QUESTIONS MUST BE ANSWERED

1. Is there any Group Health Plan:
   - now in force and to be continued? □ Yes □ No
   - currently being applied for? □ Yes □ No

   If "Yes", identify the name of the Group Health Plan, give a description of the plan(s) and name of insurance carrier(s):_____

2. Name of present or prior group carrier: _____

   Effective date of prior coverage:_____ Cancellation/termination date: _____

   Is the coverage applied for in this application replacing other group insurance? □ Yes □ No

   If "Yes", give reason _____

   Plan being replaced: _____

3. To the best of your knowledge are there any current or former employees or their eligible dependents whose health insurance is being continued? □ Yes □ No

Please provide the following information for each current/former employee or dependent on health continuations.

Name of Employee/Dependent	Date of Birth	Type of Continuation State/Federal	Reason for Termination Disability/Other	Continuation Dates Start	End

If additional space is needed, attach a separate sheet, signed and dated.

4. To the best of your knowledge:
   a. Are any employees or dependents presently incapacitated? □ Yes □ No
   b. Are any dependent children incapable of self-support due to a physical or mental disability? □ Yes □ No

Additional space to explain if items 1, 2 or 3 were answered "Yes". Refer to the question number, and give details including names, where appropriate.

_____

5. Does the employer participate in an arrangement with a Professional Employer Organization? □ Yes □ No

SECTION IV: AGENT/PRODUCER INFORMATION AND UNDERWRITING GROUP ENROLLMENT USE

Agent Producer Information (This information must be answered completely)

BROKER SIGNATURE ____________________ DATE ____________________ VENDOR NUMBER ____________________

BROKER-NAME | NAME OF AGENCY | TELEPHONE NUMBER

STREET | CITY | STATE | ZIP CODE

SUB-PRODUCER INFORMATION AND COMMISSION SPLIT

Sub-Producer Information (This information must be answered completely)

SUB-PRODUCER SIGNATURE | DATE | NPN NUMBER

SUB-PRODUCER NAME | NAME OF AGENCY | TELEPHONE NUMBER

STREET | CITY | STATE | ZIP CODE

____________________%
Sub-Producer Commission Percentage

SUB-PRODUCER SIGNATURE | DATE | NPN NUMBER

SUB-PRODUCER NAME | NAME OF AGENCY | TELEPHONE NUMBER

STREET | CITY | STATE | ZIP CODE

____________________%
Sub-Producer Commission Percentage

SUB-PRODUCER SIGNATURE | DATE | NPN NUMBER

SUB-PRODUCER NAME | NAME OF AGENCY | TELEPHONE NUMBER

STREET | CITY | STATE | ZIP CODE

____________________%
Sub-Producer Commission Percentage

SUB-PRODUCER SIGNATURE | DATE | NPN NUMBER

SUB-PRODUCER NAME | NAME OF AGENCY | TELEPHONE NUMBER

STREET | CITY | STATE | ZIP CODE

____________________%
Sub-Producer Commission Percentage

SPECIAL INSTRUCTIONS

SECTION V: SIGNATURE

It is understood that, except as provided under applicable regulations, no individual shall become covered while not actively at work on a full-time basis, and only full-time employees are eligible. (Refer to the definition on the Small Employer Certification Horizon Level Select). It is further understood that no agent has power on behalf of Horizon Blue Cross Blue Shield of New Jersey to make or modify any request or application for insurance or to bind Horizon Blue Cross Blue Shield of New Jersey by making any promise or representation or by giving or receiving any information.

It is further understood that no coverage will be effective unless and until the application is accepted in writing by Horizon Blue Cross Blue Shield of New Jersey. Final rates will be based on enrollment data as of the Policy effective date. No contract is to be implied in any way on the basis of the completion and/or submission of this application.

It is understood that I am responsible to provide Horizon Blue Cross Blue Shield of New Jersey with timely and accurate information regarding the date of hire for new employees and that the requested effective date of coverage will properly apply any orientation period and waiting period requirements applicable to my plan.

□ Please read this statement and check to confirm. I confirm that I have received the Summary of Benefits and Coverage (SBC) documents associated with the plan or plans I selected on this application. I confirm I will provide SBCs to plan participants and beneficiaries as required by federal regulations and guidance related to the distribution of the SBC, including the requiring for timing and delivery.

Any person who includes any false or misleading information on this application may be subject to criminal and civil penalties.

Dated at_____ on _____

_____ _____

Print name of Officer, Partner or Proprietor | Signature of Officer, Partner or Proprietor

_____

Witness to Signature

Note: If there are any modifications to the statements and answers given in this application (i.e., crossed out, whited-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification

SMALL EMPLOYER CERTIFICATION
HORIZON LEVEL SELECT

Legal Name and Address of Employer: _____
Name

_____
Street City State ZIP

Group Policy Number or Group Number: _____
(if a current customer)

For purposes of certification as a New Jersey Small Employer, an Employer is considered to be a Small Employer if the Employer satisfies the definition set forth below.

Employee and Small Employer Definitions
The definition of Small Employer counts employees as defined below.

Employee means an employee of the Policyholder. An individual and his or her legal spouse when the business is owned by the individual or by the individual and his or her legal spouse, partners in a partnership, sole proprietors, a 2-percent S corporation shareholder and independent contractors are **not** employees of the Policyholder.

Small Employer means in connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding Calendar Year and who employs at least 1 employee on the first day of the Plan Year.

All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer.

In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

The following calculation must be used to determine if an employer employs at least 1 but not more than 50 employees. For purposes of this calculation:

a) Employees working 30 or more hours per week are full-time employees and each full-time employee counts as 1;

b) Employees working fewer than 30 hours per week are part-time and counted as the sum of the hours each part-time employee works per week multiplied by 4 and the product divided by 120 and rounded down to the nearest whole number.

Add the number of full-time employees to the number that results from the part-time employee calculation. If the sum is at least 1 but not more than 50 the employer employs at least 1 but not more than 50 employees.

Please note: Small Employer includes an employer that employs more than 50 full-time employees if the employer's workforce exceeds 50 full-time employees for no more than 120 days during the calendar year and the Employees in excess of 50 who were employed during such 120-day or fewer period were seasonal workers.

Full-Time Employee Definition
The definition of Full-time Employee is used to determine eligibility for coverage under a small employer plan. Full-time employees are counted when determining participation for a small employer.

Full-Time Employee means an employee who works a normal work week of 25 or more hours. Work must be at the Policyholder's regular place of business or at another place to which an employee must travel to perform his or her regular duties for his or her full and normal work hours.

Please note that the above definition of Small Employer above considers full-time to be 30 hours per week and that definition of full-time is used solely for determining whether an employer is a Small Employer. For purposes of determining which employees are eligible for coverage under a Small Employer plan and whether the Small Employer meets the participation requirement, full-time is defined as 25 hours per week.

Please indicate below the number of employees by work location/State. Refer to the definition of "employee" on page 1. All employees must be included, regardless of whether or not they currently have medical coverage and through whom that coverage is provided.

Work Location (list by State)	Number of Employees or Former Employees			
	Full-time	Part-time	COBRA or State Continuees	Other

The following information will be used to calculate the **participation** rate. Refer to the definition of "full-time employee" on page 1 that counts employees working 25 or more hours per week.

Total # Full-time Employees _____

Total # Full-time Employees applying/enrolling for health benefits coverage _____

Total # Employees in an ineligible class or classes _____

The following information will be used to determine how certain federal laws apply to the Small Employer.

Is your firm subject to Working Aged Provisions of federal law (TEFRA/DEFRA)? □ Yes □ No

(You may be subject to the law if you employed 20 or more employees for 20 weeks in the current or prior calendar year)

If yes, provide the number of full-time and part-time employees you employed for at least 20 or more weeks in the current or prior calendar year. _____

For purposes of this question "employee" includes: full-time employees, part-time employees, seasonal employees, temporary employees, employees who are union members, owners, partners, officers and excludes self-employed persons, independent contractors (1099), directors

Is your firm subject to the requirements of the federal COBRA law? □ Yes □ No

(You may be subject to the law if you employed 20 or more employees during 50% or more of the working days during the previous calendar year.)

For purposes of this question "employee" includes: full-time employees, part-time employees, seasonal employees, temporary employees, employees who are union members, owners, partners, officers and excludes self-employed persons, independent contractors (1099), directors.

If yes, provide the number of full-time and part-time employees you employed during 50% or more of the working days during the previous calendar year. _____

Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours the part-time employee worked divided by the hours an employee must work to be considered full-time.

CERTIFICATION AS A SMALL EMPLOYER IN THE STATE OF NEW JERSEY
For a Group Health Benefits Plan

Please sign and date appropriate section indicating whether or not you meet the definition of a small employer.

☐ I certify that I qualify as a Small Employer in the State of New Jersey.

AND

☐ I certify that the information provided to Horizon Blue Cross Blue Shield of New Jersey is true and complete. I understand that if the above information is not complete or is not provided to Horizon BCBSNJ, in a timely manner, then health benefits coverage does not have to be offered or continued. I further understand that incomplete or untrue information may void health benefits coverage.

Signature of Officer, Partner or Owner *Title*

Print Name of Officer, Partner or Proprietor Date

Signature of Witness Date

☐ **I certify that I am NOT a Small Employer in the State of New Jersey, as defined above.**

Signature of Officer, Partner or Proprietor *Title*

Print Name of Officer, Partner or Proprietor Date

Signature of Witness Date

Any person who includes any false or misleading information on an application or enrollment form or certification for a health benefits plan is subject to criminal and civil penalties.

Complete this section if you have certified that the Employer is a Small Employer

***CENSUS INFORMATION**

Please include the following persons in the following list:

a. employees, owners, partners, and officers who are actively working for the employer on a regular basis, and are paid by the employer on a regular basis, whether or not they are eligible to be covered under the policy.

b. employees, owners, partners and officers who are not working, but who are currently covered under the employer's health benefits plan for reasons such as continuation of coverage or total disability.

Please use the following letters to indicate Status:

O: Owner, partner or officer
F: Full-time employee who works 25 or more hours per week
P: Part-time employee who works less than 25 hours per week
S: Seasonal employee (employee works 120 days or fewer per year)
D: Totally Disabled employee
C: Continuee under state or federal law
U: Employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement.

Name	Job Title	Date of Employment	Hours Worked Per Week	Status	Work Location (State)	Date of Birth
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						

*If additional space is needed, attach a separate sheet.