Horizon

Horizon Blue Cross Blue Shield of New Jersey

# DENTAL AND VISION 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 |
|---|---|---|
| ☐ Name Change | _____/_____/_____ | _____ |
| ☐ Change Plan | _____/_____/_____ | _____ |
| ☐ Other | _____/_____/_____ | _____ |

## B. Plan Options **Please select desired plan(s) and unit(s) of coverage.**

**Pediatric Dental and Family Pediatric Dental** *(check one)*

☐ **Horizon Young Grins Stand Alone Pediatric Dental (SAPD)** (only provides benefits for dependents under age 19)

☐ **Horizon Family Grins**

☐ **Horizon Family Grins Plus**

*Marketplace certified*

**UNIT** *(check one)* ☐ Single ☐ Family ☐ Two Adults ☐ Adult & Child(ren)

**Family Dental** *(check one)*

These plans may be purchased along with the Horizon Young Grins SAPD plan.

☐ **Horizon Healthy Smiles** 100/80/50/50

☐ **Horizon Healthy Smiles** 80/50/50/50

☐ **Horizon Healthy Smiles Plus** 100/80/50/50

☐ **Horizon Healthy Smiles Plus** 80/50/50/50

Do you currently have dental coverage? ☐ Yes ☐ No If yes, please provide the following:

Dental Carrier's Name: _____

Dental Policy Number: _____

Is the dental coverage a pediatric dental plan, a dental discount plan or a preventive only plan? ☐ Yes ☐ No

**UNIT** *(check one)* ☐ Single ☐ Family ☐ Two Adults ☐ Adult & Child(ren)

**Vision** *(check one)*

☐ **Horizon Panorama Plan V**

☐ **Horizon Vista V**

**UNIT** *(check one)* ☐ Single ☐ Family ☐ Two Adults ☐ Adult & Child(ren)

**APPLICANT'S LAST NAME** _____ **FIRST NAME** _____ **MI** _____

## C. 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: — Phone:

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

## 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.*

**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: —

**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, provide home address and explain why the address is different: _____

Home Address: Street Apt:

City: State: Zip Code + 4: —

**APPLICANT'S LAST NAME** _____ **FIRST NAME** _____ **MI** _____

**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, provide home address and explain why the address is different: _____

Home Address: Street Apt:

City: State: Zip Code + 4: —

## E. 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: _____

## F. Applicant's Signature (if applicant is under 18 years of age, provide guardian'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 Non-Group Enrollment/Change Request form.

Signature: _____ Date: _____/_____/_____

## G. Broker/General Agent Signature

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

Print Agent Name: _____

General Agent/Broker: MI5735467VN008493 Agent/Vendor ID# _____

**INSTRUCTIONS AND ELIGIBILITY REQUIREMENTS**

**Instructions**

- You must complete all sections and sign and date this form, as well as any additional pages you may need to submit with it to provide further requested information.
- Please PRINT except when a signature is requested.
- If a dependent child is disabled and you want to continue his or her coverage beyond age 26, select the "Other" box in "Other Change" in Section A and attach proof of the disability.
- For the Horizon Healthy Smiles plans there is a 6 month waiting period for basic restorative services and a 12 month waiting period for onlays and crowns, endodontics, periodontics, and prosthodontics. To waive the waiting periods, **you must provide** the name and policy number of your creditable dental coverage that is active on the day you submit your application. Creditable dental coverage is a dental plan that provides full dental coverage. It does not include a pediatric dental plan that only provides benefits for children under age 19, a dental discount plan or a preventive only dental plan.
- You must submit this form to us by mail, email or fax:

  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

**Eligibility**

- There are no age restrictions to enroll in the pediatric dental, family pediatric dental or family dental plans. However when an applicant age 19 or older enrolls in a Horizon Young Grins SAPD plan, he or she will not be charged premium and will not have pediatric dental benefits.
- You MUST be a New Jersey resident which means you must have a primary residence in New Jersey.
- You may purchase a Horizon Young Grins SAPD along with a Horizon Healthy Smiles or Horizon Healthy Smiles Plus plan.
- For the Horizon Vision plans there is a 7 day waiting period after the effective date of coverage, before vision claims will be paid.

**Effective Dates:**

- If you enroll on the 1st through the 14th of the month, the effective date is the 15th of the current month. If you enroll on the 15th through the end of the month, then coverage is effective on the 1st of the following month.

**Conditions Of Enrollment - Applicant Acknowledgment And Agreements**

On behalf of myself and the dependents listed in this Non-Group Enrollment/Change Request form, I acknowledge that:

- I agree Horizon BCBSNJ[1] will provide coverage in accordance with the terms of the contract(s) for which I apply.
- I understand that my enrollment and the enrollment of my listed dependents is conditioned upon acceptance by Horizon BCBSNJ.
- I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the contract(s) if premiums are not paid timely.

**Misrepresentations**

Any person who includes any false or misleading information on this form is subject to criminal and civil penalties.

[1]Horizon BCBSNJ refers to Horizon Healthcare Services, Inc., doing business as Horizon Blue Cross Blue Shield of New Jersey or any of its wholly owned subsidiaries including Horizon Insurance Company, Horizon Healthcare Dental, Inc., and Horizon Healthcare of New Jersey doing business as Horizon NJ Health.