Horizon Blue Cross Blue Shield of New Jersey

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

NON-GROUP PLAN CHANGE REQUEST FORM FOR 2017 EFFECTIVE DATES

(Please Print)

A. Plan Change Request – to be completed by the policyholder.

Requested Effective Date is based on when we receive a completed application. **(Must check one):**

☐ 1/1/2017 for applications received on or before 12/31/2016.

☐ The first or the fifteenth of the month after receipt for applications received between 1/1/2017 through 1/31/2017.

B. Policyholder Information

Last Name: First Name: MI:

Member ID# 3HZN Date of Birth: MM DD YYYY Phone:

E-Mail Address

Primary Residence: Street Apt.:

City: State: Zip Code + 4: —

Are you still a resident of New Jersey: Yes: ☐ No: ☐

Are you or any of your covered dependents eligible for Medicare?

You: Yes: ☐ No: ☐ **Your Dependents:** Yes: ☐ No: ☐

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 D. below 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 Certificate of Exemption from the Marketplace if you are age 30 or older.

OMNIA Plans

☐ OMNIA Gold

☐ OMNIA Silver

☐ OMNIA Silver HSA

☐ OMNIA Bronze

Pediatric Dental *(Required)*

Stand Alone Pediatric Dental (SAPD) Plan: 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 indicate below that you have purchased an SAPD plan with another carrier.** Persons age 19 or older enrolled in Horizon Young Grins will not be charged any premium and will not have pediatric dental benefits.

☐ 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.

D. 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. Policyholder

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: _____

Policyholder's Information

Member ID#

3HZN

Last Name: First Name: MI:

D. Horizon Advantage Plans PCP Selection (continued)

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: _____

5. 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: _____

E. Payment Information – Do not send money now. We will bill you if you are eligible to change your coverage.

F. Policyholder's Signature

I represent that all the information supplied in this Non-Group Plan Change Request Form is true and complete. I hereby agree to the conditions of enrollment set forth in this form.

Signature: _____ Date: _____/_____/_____

G. Broker/General Agent Signature

Signature of Preparer: _____ Date: _____/_____/_____ NJ Producer License#: _____

Print Agent Name: _____

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

Horizon Blue Cross Blue Shield of New Jersey

INSTRUCTIONS
NON-GROUP PLAN CHANGE REQUEST FORM
FOR 2017 EFFECTIVE DATES

Instructions

- This form is used to change from one non-group plan to another non-group plan. It cannot be used to add or remove dependents.
- You must complete all sections and sign and date this form and any additional pages you may need to submit with it to provide further requested information. Please PRINT except when a signature is requested.
- You can obtain the providers' correct names and addresses from the appropriate provider directory. You may also obtain each provider's NPI number and LOC code from the provider directory or at: **HorizonBlue.com**. Providers with multiple office locations and individual providers who belong to more than one practice or provider entity may have more than one NPI number. You should confirm the correct NPI number for the specific provider and office location where you will be seen by contacting that office directly.
- For provider addresses, include the zip code plus the four digit extension (9 digits).
- IF YOU HAVE ANY QUESTIONS concerning the benefits and services provided by or excluded under this policy, contact a Horizon Blue Cross Blue Shield of New Jersey Sales Representative at 1-844-274-0911 or your broker before signing this form.
- MAKE A COPY OF THIS COMPLETED APPLICATION! A copy of this application may be used as a temporary ID card for 30 days from the effective date if authorized by Horizon BCBSNJ. Coverage must be verified with Horizon BCBSNJ prior to visiting with a specialist or admission to a hospital.
- You may submit this form to us by mail, fax or email:

  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

A. Eligibility requirements are set forth under the Individual Health Change Reform Act of 1992, P.L. 1992, c. 161 (N.J.S.A. 17B:27A-2 et seq.).

B. You MUST be a New Jersey resident.

C. You must not have other health coverage besides the individual plan you currently wish to replace. "Other Health Coverage" includes coverage under a: group health plan resulting from employment, whether with a private or public (governmental) employer, including such coverage continued through a COBRA election or state continuation provisions; a church plan, Medicare, or another individual health benefits plan.

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

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer reporting agency, and any employer to give Horizon BCBSNJ[1] or any consumer reporting agency acting on behalf of Horizon BCBSNJ information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that Horizon BCBSNJ has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one.
4. I agree Horizon BCBSNJ will provide coverage in accordance with the terms of the contract for the individual plan.
5. I understand that my enrollment and the enrollment of my listed dependents in Horizon BCBSNJ's individual plan 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 individual policy if premiums are not paid timely.

Misrepresentations: Any person who includes any false or misleading information on a Non-Group Plan Change Request Form for a health benefits plan 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.