RESET

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
Apply online: **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	____/____/____		☐ Other	____/____/____	_____

(See instructions for triggering events, check triggering event below and attach proof)

- ☐ Loss of minimum essential coverage/loss of coverage
- ☐ Dependent attained age 26 or 31 and lost coverage
- ☐ Marriage
- ☐ Birth/adoption/foster care/child support order/ other court order
- ☐ Access to new plan due to permanent move
- ☐ No longer eligible for Marketplace subsidy
- ☐ NJ FamilyCare denial
- ☐ Domestic abuse or spousal abandonment
- ☐ Confirmation of pregnancy by a health provider
- ☐ Enrollment or non-enrollment error by entity or carrier violation
- ☐ Access to a health reimbursement arrangement

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: – Home Phone: Cell 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: — Home 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.

- [ ] Horizon Advantage EPO Silver
- [ ] Horizon Advantage EPO Bronze
- [ ] Horizon Advantage EPO Essentials

For the Essentials plan 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 Silver Value
- [ ] OMNIA Bronze

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 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 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 Primary Care Provider (PCP) Selection

Horizon Advantage Plans - selecting a PCP for each person is not required. However, a specialist copay will apply if you do not select a PCP or visit your selected PCP.

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: _____

Attach additional pages if necessary, signed and dated by you.

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 ☐ Discover

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#: _____

Print Agent Name: _____

General Agent/Broker: MIG5735467VN Agent/Vendor ID# 008493

INSTRUCTIONS AND ELIGIBILITY REQUIREMENTS

Instructions

- Except for section G, you must complete sections A through I, 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.
- For Section A-Type of Activity:
  - ➢ If you are applying to add a spouse, civil union partner, domestic partner, or child, use the "Add" section and check the applicable box. If the member being added is due to a triggering event, also use the "Other Change" section, check the box "Special Enrollment Period" and check the applicable reason.
  - ➢ If you are applying due to a triggering event that resulted in a Special Enrollment Period, use the "Other Change" section, check the box "Special Enrollment Period", check the applicable reason and attach proof of the triggering event.
    - Loss of minimum essential coverage/loss of coverage includes:
      -loss of eligibility for minimum essential coverage or medically needy coverage but not if lost due to non-payment of premium;
      -voluntary or involuntary non-renewal of a non-calendar year plan;
      -loss of pregnancy-related coverage or access to health care services through coverage for your unborn child.
    - Dependent attained age 26 or 31 and lost coverage.
    - Marriage (at least 1 spouse must have had coverage for at least 1 day within the prior 60 days).
    - Birth, adoption or placement for adoption, placement in foster care or gaining a child through a child support order or other court order, but only you and the new dependent are eligible for the special enrollment.
    - Gained access to New Jersey plans as a result of a permanent move to New Jersey (must have had coverage for at least 1 day within the prior 60 days).
    - Marketplace determination that you are no longer eligible for a subsidy.
    - Application to NJ FamilyCare submitted during the Open Enrollment Period or during a Special Enrollment Period is found ineligible.
    - Domestic abuse or spousal abandonment necessitating coverage apart from the perpetrator.
    - Confirmation of pregnancy by a health care provider.
    - Erroneous enrollment or non-enrollment due to error, misrepresentation, misconduct or inaction of entity providing enrollment assistance or a carrier's violation of a material provision of the plan in relation to a covered person.
    - Your effective date under a health reimbursement arrangement known as either an ICHRA or QSEHRA.
  - ➢ If a dependent child is disabled and you want to continue his or her coverage beyond age 26, use the "Other Change" section, check the box "Other", describe the reason and attach proof of disability.
- Eligible for Medicare means the person satisfies the requirements for Medicare but has not yet enrolled for Medicare. Covered under Medicare Parts A or B means you have Medicare and CANNOT enroll for an individual plan.
- If the plan you select recommends you choose a Primary Care Provider (PCP), 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/doctorfinder**. 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 Sales Representative at **1-888-425-5611** 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. Coverage must be verified with Horizon prior to visiting with a physician or admission to a hospital.
- You may submit this form to us by mail, email or fax or apply online:

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
Apply online: **HorizonBlue.com**

Medical Eligibility

A. Eligibility requirements are set forth under the Individual Health Coverage 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 which means your primary residence is in New Jersey.

C. You must NOT be covered under Medicare Parts A or B.

D. If application is made for the Horizon Advantage EPO Essentials Plan the following additional requirements apply:
   1. You must be under 30 years old, or
   2. You must have a notice that you qualify for an exemption with an exemption certificate number (ECN) from the Marketplace. Attach a copy of that notice to your application.

The **Annual Open Enrollment Period** begins November 1 and ends January 31 each year, and is the designated period of time during which you may apply for or change coverage for yourself and family members who are currently uninsured or who are covered under another individual plan, or who are covered under a group health plan, group health benefits plan, a governmental plan, or a church plan. Your application must be signed, dated and mailed during the Annual Open Enrollment Period. If you apply for coverage by December 31, the effective date of coverage will be January 1 of the immediately following year. If you apply for coverage between January 1 and January 31, the effective date of coverage will be February 1 of the same year.

A **Special Enrollment Period** that lasts for 60 days follows the listed Triggering Events. The effective date of a new policy will be no later than the 1st or 15th of the month following receipt of the application. In addition, if the Triggering Event is the loss of eligibility for minimum essential coverage, the Special Enrollment Period includes the 60 days prior to the Triggering Event.

NOTE: If you currently have coverage the plan for which you are applying must REPLACE the current coverage but you SHOULD NOT terminate it until the new coverage is effective.

Pediatric Dental Eligibility:

A. There are no age restrictions to enroll in the pediatric dental or family pediatric 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. The Horizon Young Grins SAPD plan only provides coverage until the end of the month a person turns age 19.

B. You MUST be a New Jersey resident which means your primary residence is in New Jersey.

C. If you enroll in a pediatric dental or family pediatric dental plan at the same time you enroll in a medical plan your pediatric dental or family pediatric dental coverage will become effective on the same date as your medical coverage. If you enroll in a pediatric dental or family pediatric dental plan at any other time and you enroll on the 1st through the 14th of the month, the effective date is the 15th of the month. If you enroll on the 15th through the end of the month, the effective date is the 1st of the following month.

CONDITIONS OF ENROLLMENT - APPLICANT ACKNOWLEDGMENT AND AGREEMENTS

On behalf of myself and the dependents listed in this Enrollment/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 Enrollment/Change Request 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 subject to acceptance by Horizon BCBSNJ.
6. 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 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.