Individual Enrollment Checklist

Horizon BCBSNJ

Thank you for using Health Plan One to obtain your individual health insurance. Follow the steps below to finalize your enrollment.

1. **Horizon BCBS NJ Application -**
   To be completed by all enrolling individuals.
   Make sure you sign and date the form in section K, Applicant Signature.

2. **Premium Payment**-
   Select Payment Method under section J, Payment Information. If paying by check or money order, please include the first month's premium payment.

3. **Please mail application and first months premium payment to:**

Health Plan One
1000 Bridgeport Ave., 4th FL
Shelton, CT 06484
Toll Free: 877.567.5267
Fax: 888.342.1612

Enrollment Form

Horizon Blue Cross Blue Shield of New Jersey

1. Please read the instructions on the back page before completing this enrollment form.

2. Please print clearly.

3. You must sign and date the enrollment form.

IMPORTANT THINGS TO REMEMBER WHEN FILLING OUT THE ENROLLMENT FORM

Omitting any of the below sections may delay the processing of your enrollment form.

Section of the Enrollment Form	Situation	Required Support for Timely Processing
Section B	65 years or older and not eligible for Medicare.	If you are ages 65 years or older, please **submit** your Medicare non-eligibility letter.
Section B	Ensure the following are completed.	Name, Social Security Number (SSN), date of birth and primary residence.
Section B	Applicant does not have a SSN.	**Attach one** of the following: Permanent Status Visa, Green Card or Resident Alien Card.
Section B/D	If your spouse's last name is different than yours, or you are a Civil Union/Domestic Partner with or without the same last name.	**Attach** either Marriage Certificate, Civil Union license/certificate or Certificate of Domestic Partnership
Section B/D	Other coverage. **Certificate of Creditable Coverage is needed (COCC).***	**Please check off** applicable box(es) and supply the name and address of your current insurance company, your identification number and group number, number of dependents listed under the policy, effective and termination date(s) and cost sharing requirements for both current and previous coverage.
Section C	Plan option.	Please ensure that you have **checked off** your plan option; enrollment will not be processed unless filled in correctly.
Section D/G	If your dependent's last name is different than the primary applicant.	**Attach** a letter explaining "why" and provide the last name and address for that dependent.
Section E	Pre-existing conditions **Certificate of Creditable Coverage is needed (COCC).***	Complete all questions regarding prior treatments and/or conditions listed on the enrollment form: Primary Applicant, Spouse, Civil Union/Domestic Partnerships and Dependent(s). If you should check a treatment and/or condition, please provide the details for each on a separate piece of paper.
Section I	Payment information.	Your monthly premium payment is due at the time your enrollment form is submitted to Horizon Blue Cross Blue Shield of New Jersey. You can find your current monthly premium by looking at the enclosed rate sheet, contacting your broker or Horizon BCBSNJ sales representative or by visiting our website <**www.HorizonBlue.com**>.
Section J	Applicant's signature.	Please **sign and date** the enrollment form for timely processing.
Section J	Applicant is a minor (under the age of 18).	Please **supply** a letter with the enrollment form explaining if the child is eligible for coverage under either parent.

*In order to review if any pre-existing waiting period can be waived, a Certificate of Creditable Coverage (COCC) or a letter on the prior carrier's letterhead must be submitted indicating the effective and termination dates of coverage. Horizon BCBSNJ will review the document for any pre-existing waiting period that may apply.

If your COCC is not available upon submission of your enrollment form, please mail it to:

Horizon Blue Cross Blue Shield of New Jersey
P.O. Box 1330
Newark, NJ 07101-1330
Or fax it to: 1-973-274-4450

An independent licensee of the Blue Cross and Blue Shield Association.
® Registered mark of the Blue Cross and Blue Shield Association.
®´ and SM Registered and service marks of Horizon Blue Cross Blue Shield of New Jersey.
© 2010 Horizon Blue Cross Blue Shield of New Jersey,
Three Penn Plaza East, Newark, New Jersey 07105

Horizon℠

Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work℠

Horizon Blue Cross Blue Shield of New Jersey

NON-GROUP ENROLLMENT/CHANGE REQUEST

Attn: Consumer Enrollment Dept.
P.O. Box 1330
Newark, NJ 07101-1330
www.HorizonBlue.com

A. Type of Activity – to be completed by Applicant *Check all that apply*

1. ADD

	Effective Date/Date of Event	Reason		Effective Date/Date of Event	Reason
☐ Enrollment of a new Subscriber	____/____/_____	______________	☐ Add Domestic Partner	____/____/_____	______________
☐ Add Spouse	____/____/_____	______________	☐ Add Dependent Child	____/____/_____	______________
☐ Add Civil Union Partner	____/____/_____	______________			

2. REMOVE

☐ Remove Subscriber	____/____/_____	______________	☐ Remove Domestic Partner	____/____/_____	______________
☐ Remove Spouse	____/____/_____	______________	☐ Remove Dependent Child	____/____/_____	______________
☐ Remove Civil Union Partner	____/____/_____	______________			

3. OTHER CHANGE

☐ Name Change	____/____/_____	______________	☐ Change Plan	____/____/_____	______________
☐ Add/Change Office ID Numbers: Primary Care Provider	____/____/_____	______________	☐ Other	____/____/_____	______________

B. Applicant Information

☐ Add ☐ Remove ☐ 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

Are you a resident of New Jersey? ☐ Yes ☐ No

Primary Residence: Street ______________ Apt.: ______

City: ______________ State: ______ Zip Code: ______ Home Phone: ______________ E-Mail Address: ______________

Do you maintain a home in any other state? ☐ Yes ☐ No *If yes:* Name of State: ______________ Number of months you live there each year: ______

Other Residence: Street ______________ Apt.: ______

City: ______________ State: ______ Zip Code: ______ Home Phone: ______________

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

Primary Care Provider Name: ______________ Current Patient: ☐ Yes ☐ No

Primary Care Provider Address: ______________

City: ______________ State: ______ Zip Code + 4: ______ – ______

NPI #: ______________ Loc Code: ______________

Are you covered under Other Health Coverage? ☐ Yes ☐ No *If yes:* Payer Name: ______________

Policy #: ______________ Medicare ID#, if any: ______________

Why are you applying for individual coverage? ______________

Are you **eligible but not covered** under Other Health Coverage? ☐ Yes ☐ No *If yes, what is it?*

☐ Group plan via employment *(specify payer)*: ______________

☐ Medicaid/NJFamilyCare ☐ Medicare ☐ Other *(specify):* ______________

Previous Coverage? ☐ Yes ☐ No *If yes:* Payer Name; ______________

Policy #: ______________ Effective Date: ______________ (MM DD YYYY) Termination Date: ______________ (MM DD YYYY)

Submit a copy of the Certificate of Creditable Coverage

What was it?
☐ Individual ☐ Group
☐ Medicaid/NJFamilyCare
☐ Other *(specify):* ______________

What Plan Type?
☐ Indemnity ☐ PPO ☐ POS ☐ HMO
☐ Other *(specify):* ______________

Cost-sharing requirements:
Deductible Amount: $ ______________
Coinsurance Amount: ______________%
Copayment Amount: $ ______________

Did coverage terminate as a result of fraud or failure to pay premiums?	☐ Yes	☐ No
Were you allowed to make a COBRA continuation election, or a continuation election under State law, if any, when coverage ended?	☐ Yes	☐ No
If yes, did you elect to continue and remain covered for the entire continuation period available to you?	☐ Yes	☐ No
Were you covered for 18 months or more under any previous plan(s)?	☐ Yes	☐ No
Have you experienced more than a 63-day break in coverage between any previous plan, including your most recent plan and the date of this application?	☐ Yes	☐ No

POLICYHOLDER'S LAST NAME, FIRST NAME, AND MI ______

C. Plan Option *Check One*

☐ Single ☐ Family ☐ Husband & Wife, Domestic Partners or Civil Union Partners ☐ Adult & Child

HMO Plan: ☐ $15 Copayment ☐ $30 Copayment ☐ $30 PCP/$50 Specialist Copayment

☐ $50 PCP/$70 Specialist Copayment ☐ $2500 Deductible/50% Coinsurance

☐ Horizon Direct Access Plan A/50 70/50

☐ Horizon Direct Access Plan C 80/70

☐ Horizon Direct Access Plan C 100/70

☐ Basic and Essential EPO

☐ Basic and Essential EPO Plus

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: ______ First Name: ______ MI: ___

Social Security #: ______ Date of Birth: MM DD YYYY ______ Sex: ☐ M ☐ F

Employed ☐ Yes ☐ No *If Yes, complete section F1* Home address same as Applicant ☐ Yes ☐ No *If No, complete section F2*

Primary Care Provider Name: ______ Current Patient ☐ Yes ☐ No

Primary Care Provider Address: ______

City: ______ State: ______ Zip Code + 4: ______ – ______

NPI #: ______ Loc Code: ______

Previous Coverage ☐ Yes ☐ No *If yes:* Payer Name: ______

Policy #: ______ Effective Date: MM DD YYYY ______ Termination Date: MM DD YYYY ______

Submit a copy of the Certificate of Creditable Coverage

What was it?

☐ Individual ☐ Group

☐ Medicaid/NJFamilyCare

☐ Other *(specify)*: ______

What Plan Type?

☐ Indemnity ☐ PPO ☐ POS ☐ HMO

☐ Other *(specify)*: ______

Cost-sharing requirements:

Deductible Amount: $ ______

Coinsurance Amount: ______%

Copayment Amount: $ ______

Why did coverage end? ______

Was continuation upon termination an option? ☐ Yes ☐ No

If yes, was continuation elected and coverage retained for full continuation period? ☐ Yes ☐ No

Does total previous coverage equal 18 months or more? ☐ Yes ☐ No

Any breaks in coverage of more than 63 days? ☐ Yes ☐ No

Covered under Other Health Coverage now? ☐ Yes ☐ No *If yes:* Payer Name: ______

Policy #: ______ Medicare ID#: ______

Eligible but not covered under Other Health Coverage? ☐ Yes ☐ No *If yes, identify the type:*

☐ Group Payer: ______

☐ Medicaid/NJFamilyCare ☐ Medicare ☐ Other *(specify)*: ______

POLICYHOLDER'S LAST NAME, FIRST NAME, AND MI ____________________

2. CHILD ☐ Add ☐ Remove ☐ Other

Last Name: ____________________ First Name: ____________________ MI: ____

Social Security #: ____________________ Date of Birth: ____________________ (MM DD YYYY) Sex: ☐ M ☐ F

If last name is different from applicant's please explain: ____________________ Living with Applicant? ☐ Yes ☐ No *If No, complete Section G*

Primary Care Provider Name: ____________________ Current Patient: ☐ Yes ☐ No

Primary Care Provider Address: ____________________

City: ____________________ State: ______ Zip Code + 4: __________ — ______

NPI #: ____________________ Loc Code: ____________________

Previous Coverage? ☐ Yes ☐ No *If yes:* Payer Name: ____________________

Policy #: ____________________ Effective Date: ____________________ (MM DD YYYY) Termination Date: ____________________ (MM DD YYYY)

Submit a copy of the Certificate of Creditable Coverage

What was it?	What Plan Type?	Cost-sharing requirements:
☐ Individual ☐ Group	☐ Indemnity ☐ PPO ☐ POS ☐ HMO	Deductible Amount: $ __________
☐ Medicaid/NJFamilyCare	☐ Other *(specify)*: __________	Coinsurance Amount: __________%
☐ Other *(specify)*: __________		Copayment Amount: $ __________

Why did coverage end? ____________________

Was continuation upon termination an option? ☐ Yes ☐ No If yes, was continuation elected and coverage retained for full continuation period? ☐ Yes ☐ No

Does total previous coverage equal 18 months or more? ☐ Yes ☐ No Any breaks in coverage of more than 63 days? ☐ Yes ☐ No

Covered under Other Health Coverage now? ☐ Yes ☐ No *If yes:* Payer Name: ____________________

Policy #: ____________________ Medicare ID#: ____________________

Eligible but not covered under Other Health Coverage? ☐ Yes ☐ No *If yes, identify the type:*

☐ Group Payer: ____________________ ☐ Medicaid/NJFamilyCare ☐ Medicare ☐ Other *(specify)*: __________

3. CHILD ☐ Add ☐ Remove ☐ Other

Last Name: ____________________ First Name: ____________________ MI: ____

Social Security #: ____________________ Date of Birth: ____________________ (MM DD YYYY) Sex: ☐ M ☐ F

If last name is different from applicant's please explain: ____________________ Living with Applicant? ☐ Yes ☐ No *If No, complete Section G*

Primary Care Provider Name: ____________________ Current Patient: ☐ Yes ☐ No

Primary Care Provider Address: ____________________

City: ____________________ State: ______ Zip Code + 4: __________ — ______

NPI #: ____________________ Loc Code: ____________________

Previous Coverage? ☐ Yes ☐ No *If yes:* Payer Name: ____________________

Policy #: ____________________ Effective Date: ____________________ (MM DD YYYY) Termination Date: ____________________ (MM DD YYYY)

Submit a copy of the Certificate of Creditable Coverage

What was it?	What Plan Type?	Cost-sharing requirements:
☐ Individual ☐ Group	☐ Indemnity ☐ PPO ☐ POS ☐ HMO	Deductible Amount: $ __________
☐ Medicaid/NJFamilyCare	☐ Other *(specify)*: __________	Coinsurance Amount: __________%
☐ Other *(specify)*: __________		Copayment Amount: $ __________

Why did coverage end? ____________________

Was continuation upon termination an option? ☐ Yes ☐ No If yes, was continuation elected and coverage retained for full continuation period? ☐ Yes ☐ No

Does total previous coverage equal 18 months or more? ☐ Yes ☐ No Any breaks in coverage of more than 63 days? ☐ Yes ☐ No

Covered under Other Health Coverage now? ☐ Yes ☐ No *If yes:* Payer Name: ____________________

Policy #: ____________________ Medicare ID#: ____________________

Eligible but not covered under Other Health Coverage? ☐ Yes ☐ No *If yes, identify the type:*

☐ Group Payer: ____________________ ☐ Medicaid/NJFamilyCare ☐ Medicare ☐ Other *(specify)*: __________

POLICYHOLDER'S LAST NAME, FIRST NAME, AND MI ______________________________

E. Pre-existing Conditions.

Check all that apply. If you check one of the conditions in #1, or respond yes to any question in #2, give details on a separate sheet of paper. This separate sheet must be signed and dated by you. This information may ONLY be used to determine if a condition is a pre-existing condition. You CANNOT be denied coverage under a health benefits plan on the basis of accurate responses to the following questions. Carriers may only use the information to expedite the processing of claims.

1. If you or any dependent to be covered has been diagnosed as having any of the following within the past six months, please place a check mark in the appropriate box:

☐ a. Alcoholism or Drug Abuse
☐ b. Arthritis
☐ c. Blood Disorder
☐ d. Back or Neck Disorder, Injury or Pain
☐ e. Cancer or Tumors
☐ f. Diabetes
☐ g. Gastro or Intestinal Disorder
☐ h. Heart Disorder/Condition /Chest Pain
☐ i. High Blood Pressure
☐ j. Kidney or Liver Disorder
☐ k. Lung or Respiratory Disorder
☐ l. Mental or Nervous Disorder
☐ m. Paralysis, Stroke or Epilepsy
☐ n. Does a pregnancy exist?
If so, provide expected due date: ____________

2. During the past six months, have you or any dependent to be covered:	Yes	No
a. been examined or treated by a physician or other health care provider for any condition, illness or injury, other than as stated above?	☐	☐
b. been advised to have treatment or surgery or testing that has not been done?	☐	☐
c. been admitted to a hospital or other health care facility as an inpatient?	☐	☐
d. taken prescribed medication?	☐	☐

F. Additional Spouse/Civil Union Partner/Domestic Partner Information

If not applicable, please mark as "NA."

1. Employer Name: ______________________________ Employer Phone: ______________

Employer Address: ______________________________

City: ______________ State: ______ Zip Code: ______________

2a. Home Address: ______________________________

City: ______________ State: ______ Zip Code: ______________

2b. Please explain why the address is different: ______________________________

G. 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: ______________________________

Street: ______________________________ Apt: __________

City: ______________ State: ______ Zip Code: ______________

Reason: ______________________________

Name: ______________________________

Street: ______________________________ Apt: __________

City: ______________ State: ______ Zip Code: ______________

Reason: ______________________________

H. 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

I. Payment Information

Indicate how you would like to make payment

☐ Check ☐ Money Order ☐ Automatic Bank Draft (attach voided check) ☐ Credit Card Type (☐ Visa ☐ Mastercard)

Credit Card No.: ______________ Exp. Date: ______/______ Cardholder Name: ______________

J. 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: _____/_____/_____

K. Broker/General Agent Signature

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

General Agent/Broker: HEALTH PLAN ONE, 1000 Bridgeport Ave., 4th FL., Shelton CT 06484 Agent/Vendor ID# 14563

Instructions

INSTRUCTIONS AND ELIGIBILITY REQUIREMENTS

Instructions

- Except for section H, you must complete sections A through J, 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 the limiting age, describe this in "Other Change" in Section A, and attach proof of disability.
- 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 appropriate provider directory or at **www.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 (11 digits).
- "Previous Coverage" and "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, Medicaid, NJFamilyCare or another individual health benefits plan.
- 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 **1-800-224-1234** or your broker before signing this form.
- KEEP 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 or Horizon Healthcare of New Jersey, Inc. Coverage must be verified with Horizon BCBSNJ or Horizon Healthcare of New Jersey, Inc. prior to visiting with a physician or admission to a hospital.

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.

C. EXCEPT as F. below applies, you and family members you wish to cover MUST NOT be eligible to be covered under a: group health plan; a group health benefits plan; a governmental plan (not including Medicaid); a church plan; or Medicare.

D. You and any family members you wish to cover are NOT eligible for a standard individual health benefits plan if covered by another individual health benefits plan UNLESS you are replacing the other individual health benefits plan by the one for which you are submitting this application.

E. If you do not specify an effective date in the application, your effective date shall be no later than the first day of the month following the month in which the completed application was dated and we receive premium payment directly or through our duly authorized agent UNLESS you submit your application during the November Open Enrollment Period (see F. below).

F. You may apply for coverage for yourself and family members who are covered under a group health plan, group health benefits plan, a governmental plan, or a church plan during the November Open Enrollment Period, if you wish to replace the current coverage with a more comprehensive individual health benefits plan. The effective date of coverage under the individual health benefits plan in this instance will be January 1 of the calendar year following the November Open Enrollment Period. You SHOULD NOT terminate current coverage until the new coverage is effective.

CONDITIONS OF ENROLLMENT - APPLICANT ACKNOWLEDGES 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, or Horizon Healthcare of New Jersey, Inc., or any consumer reporting agency acting on behalf of Horizon BCBSNJ or Horizon Healthcare of New Jersey, Inc., 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 or Horizon Healthcare of New Jersey, Inc., 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 or Horizon Healthcare of New Jersey, Inc. 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 or Horizon Healthcare of New Jersey, Inc.'s individual plan is effective upon acceptance by Horizon BCBSNJ or Horizon Healthcare of New Jersey, Inc.
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 a Nongroup Enrollment/Change Request Form for a health benefits plan is subject to criminal and civil penalties.

Horizon Blue Cross Blue Shield of New Jersey

CONSUMER/INDIVIDUAL AUTOMATIC PAY PLAN APPLICATION

Agreement Authorizing Horizon Blue Cross Blue Shield of New Jersey to Debit Account

This agreement is made between Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ)

and ____ .
(name of depositor as shown on bank records)

Horizon BCBSNJ is hereby requested and authorized to initiate deductions from the consumer's account listed below. The named banking institution (Bank) is hereby requested and authorized to charge such deductions to the checking account below.

Bank Name ________________________ Bank Account No. ______________

Bank Routing No. ______________

Bank Address ____
(address of branch where account is maintained)

It is understood and agreed that:

(1) The Consumer's bank account listed above will be debited as required to pay premiums for the consumer's health benefits contract with Horizon BCBSNJ on the premium due date.

(2) If a debit is refused by the Bank for any reason other than the Bank's error, it will be determined that payment of the premium has not been tendered by the consumer and the consumer's health benefits contract with Horizon BCBSNJ will be in arrears and subject to termination in accordance with its terms.

(3) This agreement and authorization shall remain in effect until 30 days after both Horizon BCBSNJ and the Bank receive written notification from the consumer of its termination or until the consumer's health benefits contract with Horizon Blue Cross Blue Shield of New Jersey is terminated for any reason.

(4) Please be advised that if the transaction is returned from your bank for insufficient funds, Horizon is not responsible for any bounced check fees.

Consumer Name ______________________ Consumer ID Number ____________

Date __________ Signed ____________________ Title ______________

IMPORTANT: Please attach a blank, voided check for the bank account from which deductions should be made, and mail to:

Horizon Blue Cross Blue Shield of New Jersey
3 Penn Plaza East PP-06A
Newark, New Jersey 07105-2200

An Independent Licensee of the Blue Cross and Blue Shield Association