Horizon
Horizon Blue Cross Blue Shield of New Jersey

Horizon Blue Cross Blue Shield of New Jersey
3 Penn Plaza East PP-13T
Newark, NJ 07105-2200

Small Employer Vision Group Application Instructions

Instructions

The attached form should be completed with the assistance of your authorized Broker.

Please complete all necessary forms in their entirety. Please print in ink or type your responses. Ensure that all areas requiring a **signature and date are complete.**

Completed enrollment application forms should be sent to your authorized Broker **prior to your effective date.**

Documents Included

Attached you will find the form that must be completed and submitted for each New Jersey small employer group applying for vision coverage:

- Application for a Small Employer Vision Benefits Policy.

Other Required Documents

In addition to the form listed above, depending on the preferred payment method, the following items may also be required:

- Automatic Pay Plan Application (#8977).

When submitting your paperwork as required above, you must also submit the following:

- Enrollment Change/Request Form (#6803) - One form is needed for each employee enrolling. Your authorized Broker will provide these forms.
- First month's premium - All new cases must be submitted with a company check for the first month's premium payable to Horizon BCBSNJ. If a case is submitted without a premium check, the case will be returned.
- Rate Sheet - The rate sheet generated for the group should match the product selected in Section II of the Application and the corresponding premium rates based on whether you selected Employer Paid or Employee Paid.

Mailing Instructions

Please send the completed paperwork and attachments to:

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APPLICATION FOR A SMALL EMPLOYER VISION BENEFITS POLICY

Please print or type ☐ New Policy ☐ Change in Policy Policy No. ____________ Requested Effective Date ____________

SECTION I: POLICYHOLDER INFORMATION

1. Policyholder (full legal name of company): ____________
2. Tax Identification Number: | | | | | | | | | | E-mail Address: ____________
3. Main Address: ____________
   STREET CITY STATE ZIP CODE COUNTY
   Mailing Address (Billing): ____________
   STREET CITY STATE ZIP CODE COUNTY
   Telephone: | | | |–| | | |–| | | | | Facsimile: | | | |–| | | |–| | | | |
4. Name of Company Official: ____________ Title: ____________
5. Type of Organization: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Other (explain): ____________
6. Nature of Business (specify): ____________ SIC Code: ____________
7. Number of eligible employees in your company: ____________
   (Eligible employees are those who work at least 25 hrs. per week)
8. Number of eligible employees to be insured: ____________
9. Class or classes to be excluded: ____________
10. Insurance requested for: ☐ Employees Only ☐ Employees and Dependents
11. Is the employer subject to the requirements of COBRA? ☐ Yes ☐ No
12. Waiting period before employees become insured:
    Present employees: ☐ no waiting period ☐ One month ☐ Two months ☐ 90 days
    New employees: ☐ no waiting period ☐ One month ☐ Two months ☐ 90 days
    Rehired employees: ☐ no waiting period ☐ One month ☐ Two months ☐ 90 days
13. Deposit $ ____________

Premium Paid: ☐ Monthly ☐ Automatic checking withdrawal

The premium for the first month of coverage must be attached.

Premium will be due as of the effective date.

SECTION II: SPECIFICATIONS FOR COVERAGE

Select one of the following coverage options:

☐ Horizon Vista II ☐ Horizon Panorama IV (Alt B)

☐ Horizon Panorama IV (Alt A) ☐ Horizon Expanse V

What percentage of the premium will the employer pay? ____________

Select one of the following employer contributions levels:

☐ Employer pays (employer pays 75% of more of premium)

☐ Employee pays (employer pays less than 75% of premium)

Refer to attached rate sheet

SECTION III: SIGNATURE

It is understood that no individual shall become insured while not actively at work on a full-time basis, and only full-time employees are eligible. A full-time employee is one who regularly works at least 25 hours per week at his employer's place of business. Only adults 19 and over are eligible for coverage. Dependents are eligible for coverage from age 19 through the end of the month the dependent reaches age 26. 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 Healthcare Dental Services on behalf of Horizon Blue Cross Blue Shield of New Jersey by making any promise or representation or by giving orreceiving any information.

It is further understood that no insurance will be effective unless and until the application is accepted in writing by Horizon Blue Cross Blue Shield of New Jersey. No contract of insurance is to be implied in any way on the basis of the completion and or submission of this application.

Any person who knowingly files a statement of claim, application for insurance, enrollment form, or certification containing any false or misleading information may be subject to criminal and civil penalties.

____________ Print name of Officer, Partner, or Owner

____________ Signature of Officer, Partner, or Owner

____________ Witness to Signature

Dated at ____________ on ____________

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.

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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

OTHERS (NAME, TITLE)

SPECIAL INSTRUCTIONS

FOR INTERNAL GROUP VISION ENROLLMENT USE

Coverage Code	
TOTAL APPLICATIONS SUBMITTED	
TRANSFER FROM GROUP # ______________	
EMPLOYER CONTRIBUTION	
EFFECTIVE DATE	
FUTURE RATE RENEWAL DATE	

	SALES ASSOCIATE SIGNATURE	DATE	ITEM NUMBER
APPROVED BY:	SALES ADMINISTRATION SIGNATURE	TITLE	DATE