



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
<input type="checkbox"/> Enrollment of a new Subscriber	___/___/___	_____	<input type="checkbox"/> Add Domestic Partner	___/___/___
<input type="checkbox"/> Add Spouse	___/___/___	_____	<input type="checkbox"/> Add Dependent Child	___/___/___
<input type="checkbox"/> Add Civil Union Partner	___/___/___	_____		

2. REMOVE	Date of Event	Reason	Date of Event	Reason
<input type="checkbox"/> Remove Spouse	___/___/___	_____	<input type="checkbox"/> Remove Domestic Partner	___/___/___
<input type="checkbox"/> Remove Civil Union Partner	___/___/___	_____	<input type="checkbox"/> Remove Dependent Child	___/___/___

3. Other CHANGE	Date of Event	Reason
<input type="checkbox"/> Name Change	___/___/___	_____
<input type="checkbox"/> Change Plan	___/___/___	_____
<input type="checkbox"/> Other	___/___/___	_____

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

Pediatric Dental and Family Pediatric Dental <i>(check one)</i>	<input type="checkbox"/> Horizon Young Grins Stand Alone Pediatric Dental (SAPD) (only provides benefits for dependents under age 19) <input type="checkbox"/> Horizon Family Grins <input type="checkbox"/> Horizon Family Grins Plus
<i>Marketplace certified</i>	UNIT (check one) <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Two Adults <input type="checkbox"/> Adult & Child(ren)
Family Dental <i>(check one)</i>	These plans may be purchased along with the Horizon Young Grins SAPD plan. <input type="checkbox"/> Horizon Healthy Smiles 100/80/50/50 <input type="checkbox"/> Horizon Healthy Smiles 80/50/50/50 <input type="checkbox"/> Horizon Healthy Smiles Plus 100/80/50/50 <input type="checkbox"/> Horizon Healthy Smiles Plus 80/50/50/50 Do you currently have dental coverage? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
	UNIT (check one) <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Two Adults <input type="checkbox"/> Adult & Child(ren)
Vision <i>(check one)</i>	<input type="checkbox"/> Horizon Panorama Plan V <input type="checkbox"/> Horizon Vista V
	UNIT (check one) <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Two Adults <input type="checkbox"/> 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: 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: 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: 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: 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):

[Grid for last name]

First Name:

[Grid for first name]

MI:

[MI grid]

Social Security #:

[Grid for Social Security #]

Date of Birth:

[Grid for 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

[Grid for Home Address: Street]

Apt:

[Grid for Apt]

City:

[Grid for City]

State:

[Grid for State]

Zip Code + 4:

[Grid for 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: _____ 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 BCBSNJ¹ 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.

¹Horizon 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.