



Horizon Blue Cross Blue Shield of New Jersey

Small Employer Dental 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.

Application Attached you will find the Application for a Small Employer Dental Benefits Policy that must be completed and submitted for each New Jersey small employer group applying for dental coverage.

**Other
Required
Documents**

When submitting your paperwork as required above, you must 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.

If you select the automatic checking withdrawal option, you must also submit an Automatic Pay Plan Application (#8977).

**Horizon
Healthy
Smiles**

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, prosthodontics and orthodontics (if applicable). To waive the waiting periods, you must provide the name of your dental carrier and the dental group 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 members under age 19, a dental discount plan or a preventive only dental plan.

**Mailing
Instructions**

Please send the completed paperwork and attachments to:

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



Horizon Blue Cross Blue Shield of New Jersey



APPLICATION FOR A SMALL EMPLOYER DENTAL BENEFITS POLICY

Horizon Blue Cross Blue Shield of New Jersey Dental Programs 3 Penn Plaza East PP-13T Newark, NJ 07105-2200 1-800-4-DENTAL

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: Mailing Address (Billing): 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: 8. Number of eligible employees to be insured:
9. Class or classes to be excluded:
10. Insurance requested for: [] Employees Only [] Employees and Dependents
Should the plan provide coverage for domestic partners as permitted by P.L. 2003, c. 246? [] Yes [] No
11. Is the employer subject to the requirements of COBRA? [] Yes [] No
12. Waiting period before employees become insured: (may not exceed 6 months) Present Employees: New or Rehired Employees:
13. What percentage of the premium will the employer pay? 14. Deposit \$

Premium Paid: [] Monthly [] Automatic checking withdrawal

The premium for the first month of coverage must be submitted with the application.

SECTION II: SPECIFICATIONS FOR COVERAGE

Table with 2 columns: Plan Name and Selection Options. Includes Pediatric Dental and Family Pediatric Dental (check one), and Family Dental options.

SECTION III: ALL QUESTIONS MUST BE ANSWERED

- a. Name of present or prior group carrier Effective date of prior coverage Cancellation/Termination Date
Is the coverage applied for in this application replacing other group insurance? [] Yes [] No
If "Yes", give reason Please attach copy of the prior carrier bill received in last 60 days.
b. Has your firm been uninsured for 3 or more months prior to application? [] Yes [] No

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.

SECTION IV: 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. It is further understood that no agent has power on behalf of Horizon Blue Cross Blue Shield of New Jersey, Inc. to make or modify any request or application for insurance or to bind Horizon Healthcare Dental, Inc. and/or Horizon Healthcare Services, Inc. on behalf of Horizon Blue Cross Blue Shield of New Jersey, Inc. by making any promise or representation or by giving or receiving 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, Inc. 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

Dated at _____ on _____

Witness to Signature

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 DENTAL ENROLLMENT USE

Coverage Code	c/o	_____	
TOTAL APPLICATIONS SUBMITTED	_____		
TRANSFER FROM GROUP # _____	_____		
REFUSALS/WAIVERS LISTING ATTACHED (IF APPLICABLE)	_____		
EMPLOYER CONTRIBUTION	_____		
EFFECTIVE DATE	_____		
FUTURE RATE RENEWAL DATE	_____		
_____	SALES ASSOCIATE SIGNATURE	DATE	ITEM NUMBER
APPROVED BY: _____	SALES ADMINISTRATION SIGNATURE	TITLE	DATE

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