



Horizon Blue Cross Blue Shield of New Jersey
P.O. Box 1330
Newark, NJ 07101-9845
website: www.horizon-bcbnsj.com

APPLICATION FOR INDIVIDUAL HEALTH BENEFITS PLAN FOR INDIVIDUALS AND FAMILIES

Eligibility Requirements

1. Eligibility requirements are determined under the Individual Health Coverage Reform Act of 1992, P.L. 1992, c. 161.
2. You must be a New Jersey resident.
3. You and any family members you wish to cover **must not** be eligible to be covered under:
 - (a) a Group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan;
 - (b) Medicare.
4. 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 plan unless the other plan is being replaced by the plan being applied for with this application.
5. If the requested effective date is not completed, your effective date shall be no later than the first of the month following the month in which the completed application and premium payment are received by us or our duly authorized agent. However, with respect to applications submitted during the October Open Enrollment Period by persons who are eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan, or persons who wish to replace their current health benefit plan with a more comprehensive individual health benefits plan, the effective date of your coverage shall be January 1 of the following calendar year. Current coverage should not be terminated until new coverage is in effect.

INDIVIDUAL APPLICATION INSTRUCTIONS

BEFORE COMPLETING THIS APPLICATION BE SURE TO FAMILIARIZE YOURSELF WITH THE BENEFIT OPTIONS AVAILABLE. PARTICIPATING PROVIDERS, INCLUDING ALL NETWORK PRIMARY CARE PHYSICIANS, ARE INDEPENDENT CONTRACTORS AND ARE NOT AGENTS OR EMPLOYEES OF HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY OR HORIZON HEALTHCARE OF NEW JERSEY, INC.

COMPLETE ALL SECTIONS IF YOU ARE:

1. Enrolling as a new subscriber.
2. Changing dependent coverage.

COMPLETE SECTIONS 1,2,3 and 7 IF YOU ARE TERMINATING YOUR COVERAGE.

- Section 1 - Print your full name along with the name(s) of your spouse and dependent children you wish to cover, if any. Provide date of birth, sex, and social security number for each individual listed. Your social security number is for our use. The New Jersey Individual Health Coverage Program Board will not collect or use your social security number. If a dependent is a full-time college student, you **must** attach a current course schedule or tuition receipt. If a dependent is beyond age 19 or 23, as applicable, but is mentally or physically handicapped or developmentally disabled, unmarried and chiefly dependent upon the applicant or applicant's spouse for support and maintenance, a physician's statement as to the dependent's physical or mental incapacity must be provided. The add/remove blocks should be checked **only** if you wish to add or remove a dependent from the plan.
- Section 2 - Complete all information.
- Section 3 - Check box(es) indicating options for coverage, type of contract, payment plan and reason(s) for submitting form (i.e., new enrollment, coverage change, name change, withdrawal).
- Section 4 - **This information is required. Please complete all information.**
- Section 5 - For Horizon HMO applicants only, from the appropriate directory choose a Primary Care Physician for yourself and each member of your family, **(required for all members)**. Check the change box only if you are changing providers.
- Section 6 - Complete all information where applicable.
- Section 7 - Applicant **must sign** this section and date this form or it will not be processed.

CONDITIONS OF ACCEPTANCE

On behalf of myself and the dependents listed on the following page, I agree to or with the following:

1. Coverage of applicant and the listed dependents shall depend on acceptance by Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc., after a review of the application and receipt of payment.
2. Applicant is applying for individual coverage for the applicant, applicant's spouse and any eligible unmarried children under nineteen (19) years of age, unmarried children who are mentally or physically incapacitated or developmentally disabled, who are chiefly dependent upon the applicant or the applicant's spouse for support and maintenance, or are unmarried children between the ages of nineteen (19) and twenty-three (23) who are full-time students at an accredited educational institution.
3. Coverage and benefits are contingent on timely payment of premiums. Coverage may be terminated as provided in the Individual Policy.
4. The Individual Policy will determine the rights and responsibilities of subscriber(s) and will govern in the event it conflicts with any benefits comparison, summary or other description of the health benefits plan.
5. For Horizon HMO only, as a condition to benefits, applicant understands and agrees that (with the exception of a medical emergency as defined in the Individual Policy), all services, in order to be covered by Horizon HMO, must be performed either by a Primary Care Physician or by the specialist, hospital or other provider as authorized by prior written referral from the Primary Care Physician or Care Manager.
6. If applicable, Applicant agrees to make payment directly to health care providers, such copayments as are provided for in the Individual Policy.
7. Applicant understands that this coverage will remain in effect regardless of the continued availability of a Primary Care Physician or other health care provider.

Please print in ink all information requested on this application.

1. Eligible Persons to be Enrolled (Note: Dependent children may be covered under an adult-child(ren) or family contract only while unmarried and until they attain age 19 or 23, if full-time students. Unmarried, handicapped dependent children can continue beyond the age limits above as long as they remain incapacitated and unmarried.)*

This section must be completed in its entirety.

LAST NAME	FIRST NAME	MI	BIRTHDATE				SEX	SOCIAL SECURITY NUMBER
			MO	DAY	YR	(M or F)		
Applicant 1. <input type="checkbox"/> Add <input type="checkbox"/> Remove								__/__/__-__/___-__/__/__/_
Spouse 2. <input type="checkbox"/> Add <input type="checkbox"/> Remove								__/__/__-__/___-__/__/__/_
Child 3. <input type="checkbox"/> Add <input type="checkbox"/> Remove								__/__/__-__/___-__/__/__/_
Child 4. <input type="checkbox"/> Add <input type="checkbox"/> Remove								__/__/__-__/___-__/__/__/_
Child 5. <input type="checkbox"/> Add <input type="checkbox"/> Remove								__/__/__-__/___-__/__/__/_

* Attach sheet to list additional children. Attach proof if full-time student. Totally disabled dependent children will be covered regardless of age. Attach proof of disability.

DEPENDENT INFORMATION

Do any of the dependents listed in #1 live at another address: Yes No If yes, who and at what address?

Explain the circumstances.

If any dependent's last name is different from yours, explain the circumstances.

2. PRIMARY RESIDENCE (Note: You must be a Resident, which is defined as follows: a person:

- whose primary residence is in New Jersey and who is present in New Jersey for at least six months of the Calendar Year; or
- in the case of a person who has moved to New Jersey less than six months before applying for coverage, who intends to be present in New Jersey for at least six months of the Calendar Year.

Street _____ Apt. _____ City _____ State _____ Zip _____

TELEPHONE NUMBER

Home () _____ Work () _____

Best place to call during the day: Home Work

Are you a resident of the State of New Jersey? Yes No Do you maintain a residence in any other state? Yes No

If "Yes," (a) Name of State _____ (b) How much time do you spend there each year? _____

3. COVERAGE (Please mark Coverage, Type of Contract and Type of Activity)

PLEASE ENROLL ME (AND MY DEPENDENTS) IN: (Only one plan and one deductible option may be selected)

- A/50 Basic Deductible \$1000 ___ \$2500 ___ \$5000 ___ \$10000 ___
- Plan B Traditional Deductible \$1000 ___ \$2500 ___
- Plan C Traditional Deductible \$1000 ___ \$2500 ___ High Deductible \$1500 ___ \$2250 ___ per individual
 \$3000 ___ \$4500 ___ per family
 Inflation Adjusted Deductible \$1650 ___ \$2500 ___ per individual
 \$3300 ___ \$4950 ___ per family
- Plan D Traditional Deductible \$ 500 ___ \$1000 ___ High Deductible \$1500 ___ \$2250 ___ per individual
 \$3000 ___ \$4500 ___ per family
 Inflation Adjusted Deductible \$1650 ___ \$2500 ___ per individual
 \$3300 ___ \$4950 ___ per family

HMO Plan \$10 Copayment \$15 Copayment \$30 Copayment

4. OTHER HEALTH CARE COVERAGE (Continued)

If you or any of your dependents are covered under an existing health benefits plan, or if you or any of your dependents had coverage which terminated within the past 31 days, please provide the following information for each person who has or had such coverage.

Name(s) of Person(s): _____

Name of Carrier: _____

Policy Number: _____

Type of Coverage: (Check all that apply) Group Individual Indemnity A B C D
 HMO PPO Point of Service Other (specify: _____)

Plan Information: Deductible Amount: _____ Coinsurance: _____ Copayment: _____

Initial Effective Date: _____ Termination Date: _____

If one or more of the persons are or were covered under a separate plan, please use this section to provide information concerning the coverage of those persons.

Name(s) of Person(s): _____

Name of Carrier: _____

Policy Number: _____

Type of Coverage: (Check all that apply) Group Individual Indemnity A B C D
 HMO PPO Point of Service Other (specify: _____)

Plan Information: Deductible Amount: _____ Coinsurance: _____ Copayment: _____

Initial Effective Date: _____ Termination Date: _____

5. PROVIDER SELECTION

FULL NAME OF PRIMARY CARE PHYSICIAN AND OFFICE ID NO.	GYNECOLOGIST OFFICE NO.	ESTABLISHED PATIENT	PRIMARY CARE PHYSICIAN CHANGE
1. Applicant		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>
2. Spouse		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>
3. Child		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>
4. Child		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>
5. Child		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>
6. Child		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>

NOTE: A Primary Care Physician **must be selected** for each adult member and a Pediatrician must be selected for each child. Women over the age of 16 must also select a GYN.

7. AUTHORIZATION AND CERTIFICATION

I hereby apply to Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc., for coverage for any eligible dependents listed above and myself.

I understand that for 12 months following the effective date of this policy, benefits are not provided for health services received for (a) conditions for which medical advice, diagnosis, care or treatment was recommended or received during the last 6 months, (b) conditions for which during the last 6 months there were symptoms which would cause a prudent person to seek medical advice, diagnosis, care, or treatment, or (c) pregnancy existing on the effective date of this policy. (Note: This limitation will not apply if you are a Federally Defined Eligible Individual and may not apply if the eligible person transfers from another health benefits plan.)

I understand that by signing below when I file a claim, Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc., may pay the health care benefits directly to the provider instead of to me.

I agree that: (a) any physician, hospital or other provider is authorized to provide Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc., or its assignee information about any eligible person's medical history; and (b) any company or person having information concerning other health care coverage in force, or available to, any eligible person may give such information to Horizon Blue Cross and Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc., or its assignee.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

I state that: (a) I am a resident of New Jersey and reside live or work within the Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc., service area (if applicable), (b) the information given on this application is complete to the best of my knowledge and belief and (c) that Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc., will rely on this information to determine eligibility. I understand that if I omit or falsify any statement in this application Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc., can cancel this contract as of the original effective date.

Applicant's Signature: _____

Date Signed: _____

Spouse's Signature: _____

Date Signed: _____

Preparer's Signature: _____

DOBI License #: _____

Date Signed: _____

NOTE TO ALL APPLICANTS: If we accept your application, a copy of the application will be sent to you. Attach the copy to your policy; it becomes part of your contract with us.

TYPE OF CONTRACT: Single Family Adult & Child(ren) Husband/Wife
 If you selected Plan C or Plan D with a \$1650 or \$2500 per individual or \$3300 or \$4950 per family deductible option, do you intend to participate in a Medical Savings Account? Yes No

REQUESTED EFFECTIVE DATE: _____

For (Plan) Use Only	Effective Date	Billing	Coverage Code	Type	Pre-Ex	Continuous Coverage	Transcode	Vendor #

TYPE OF ACTIVITY:

- New Subscriber
- Converting from existing (carrier) plan

- Name change from _____ to _____
- Change of Primary Care Physician
- Withdrawal From Coverage

ID# _____

Date of Event _____

- Add/Remove Dependent

Reason _____

Date of Event _____

SELECT THE PAYMENT PLAN YOU DESIRE

- Monthly PAYMENT MODE: Check Money Order Credit Card-Type _____
- Card No. _____ Exp. Date _____ (Visa & Mastercard only)
- Other _____ Amount \$ _____

4. OTHER HEALTH CARE COVERAGE

(Note: In some situations, if you are eligible for or have other health benefits coverage, you are not eligible for this coverage. If you or other dependents become eligible for or become covered under other health benefits coverage, after the date of this application, you must notify us as soon as possible, however, no later than the effective date of such other coverage.)

Are you employed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please give name and address of your employer:	

Are you eligible for other health benefits coverage? (i.e. coverage under your employer's health benefits coverage or Medicare)	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, give name and policy no. of other carrier or type of coverage:	

Are other dependents eligible for coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, specify:	

Do you or other dependents currently have other health care coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, give name and policy/certificate no. of other carrier, initial effective date of coverage and specify those covered by the policy/certificate:	

Are you replacing existing coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, give name and policy no. of other carrier, initial effective date of coverage, date of termination, and specify those covered by policy.	

If you are replacing coverage and the plan is an Individual Health Coverage (IHC) Plan or a Small Employer Health Benefits (SEH) Plan, please identify the letter of the plan being replaced:	

Were you or any dependent(s) to be covered, covered under a prior Group Health Plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, attach the Certificate of Creditable Coverage	