INSTRUCTIONS How to fill out the Horizon Enrollment form

EmployersYou must complete the Group Information and sections A and J in order for this application to be processed.

EmployeesYou must complete sections B through H and submit the signature of each Over-Age Child for which a Dependent Under 31 Continuation Election is made in accordance  
with Section I in order for this application to be processed.  
• Please **PRINT** except when a signature is requested.  
• If a dependent is disabled and you want to continue his or her Medical and/or Family Dental coverage beyond age 26, you do not have to make a COBRA or NJSGC or  
Dependent Under 31 election. Instead select “Other” in Section A and attach proof of total disability.  
• For Pediatric Dental and Family Pediatric Dental plans, Total Disability and COBRA are available continuation options; NJSGC and Dependent Under 31 continuation are  
not available. For Vision plans, Total Disability and COBRA are available continuation options; NJSGC and Dependent Under 31 continuation are not available.  
• For Horizon Dental Option, Horizon Dental PPO, Horizon Dental PPO Access and Horizon Dental Choice, if a dependent is a full-time college student, you must attach a  
current course schedule or a letter from the school confirming full-time student status (12 or more credits).  
• You can obtain the providers’ correct names from the appropriate provider directory. You may also obtain each provider’s NPI and LOC Code number from the 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.  
• If the Plan Option selected is Horizon Dental Choice-from the appropriate Provider directory, locate the alphanumeric office ID code for the dentist. Indicate office ID  
number selection(s) and NPI Number on the form.  
• If you are a current patient, please check the “Current Patient” box. (only applicable if the Plan Option selected is Horizon Dental Choice).  
• If the Horizon Young Grins plan is selected, ***only enrollees under age 19 can receive benefits.***  
• If Vision Plan Option is selected, ***all enrollees must be age 19 or over to qualify for benefits.***

Qualifying Events COBRA (over 20 ees on payroll) and NJSGC (under 20 ees on Payroll)  
C1. Termination of job or reduction in hours  
C2. Employee enrollment in Medicare (COBRA only)  
C3. Divorce (COBRA/NJSGC); civil union dissolution (NJSGC) or termination of domestic partnership (NJSGC)  
C4. Death of employee  
C5. Loss of dependent child status (aged out) under the plan.  
C6. Disability (occurring subsequent to another qualifying event)

**AD31 - Dependent Under 31**  
D1. Loss of dependent status (aged out) and otherwise eligible  
D2. Re-establish eligibility: residency  
D3. Re-establish eligibility: nonresident full-time student  
D4. Re-establish eligibility: change in marital status  
D5. Re-establish eligibility: change in parental status  
D6. Re-establish eligibility: termination of other coverage

Conditions of Enrollment - Applicant Acknowledgements and AgreementsOn 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 BCBSNJ1, or any consumer reporting agency acting on behalf of Horizon BCBSNJ, 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 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 will provide coverage in accordance with the terms of the contract for the group plan/policy.  
5. 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 group plan/policy if premiums are not paid timely. I authorize my Employer to withhold payments from my wages as contribution to the premium, as appropriate.

MisrepresentationsAny person who includes any false or misleading information on an Enrollment/Change Request Form for a health benefits plan is subject to criminal and civil penalties.

Notices General Notice of Special Enrollment RightsIf you are declining enrollment under your group health plan for yourself and/or your dependents (if your plan includes coverage for dependents) because of other health  
insurance or other group health plan coverage, you may be able to enroll yourself and those dependents in this group health plan if you or the dependents lose eligibility for  
that other coverage (or if the other employer stops contributing toward your or your dependents’ other coverage). However, if the other coverage was continuation coverage  
under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you must request enrollment within 30 days after the COBRA coverage ends. If the other  
coverage was not COBRA continuation coverage, you must request enrollment within 90 days after your or your dependents’ other coverage ends (or after the other employer stops contributing toward the other coverage).  
In addition, if this plan includes coverage for dependents and you acquire a new dependent as a result of marriage, birth, adoption, placement for adoption, or placement in  
foster care you may be able to enroll yourself and your dependents under this plan after declining its coverage. However, you must request enrollment within 31 days after  
the child’s birth or within 30 days after the marriage, adoption, placement for adoption, or placement in foster care.  
If you decline group health coverage under this plan, you will be asked to state in writing whether the declination was due to the existence of other health coverage.  
To request special enrollment or obtain more information about it, contact your benefits manager, if available, or your employer.

Notice on Dependent Under 31 ContinuationHorizon Blue Cross Blue Shield of New Jersey will bill over- age dependents directly and enrollees will remit the premium directly to Horizon BCBSNJ. When Dependent  
Under 31 Continuation is selected, the home address must be completed under Section “A - Type of Activity” even when it is the same as the employee’s address. Important Note:• Although the employee must continue eligibility under the dependent’s plan for continued coverage of the dependent, in addition to the additional applicable eligibility criteria, coverage for the dependent will be issued as stand-alone coverage. All cost-sharing requirements and limitations will apply and will not be combined with the employee’s  
policy. Consequently, covered expenses incurred by the over-age dependent will not contribute to family deductibles and out-of-pocket maximums, nor will family incurred expenses contribute to the over-age dependent’s deductibles or out-of-pocket maximums

Horizon Blue Cross Blue Shield of New Jersey complies with applicable Federal civil rights laws and does not discriminate against nor does it exclude people or treat them differently on the basis of race, color, gender, national origin, age, disability, pregnancy, gender identity, sex, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations. Horizon BCBSNJ provides free aids and services to people with disabilities (e.g. qualified sign language interpreters and information in other formats) and to those whose primary language is not English (e.g. information in other languages) to communicate effectively with us.

**Contacting Member Services**Please call Member Services at **1-800-355-BLUE (2583) (TTY 711) or the phone number on the back of your member ID card**, if you need the free aids and services noted above and for **all other Member Services issues.**

**Filing a Section 1557 Grievance** If you believe that Horizon BCBSNJ has failed to provide the free communication aids and services or discriminated against you for one of  
the reasons described above, you can file a discrimination complaint also known as a Section 1557 Grievance. **Horizon BCBSNJ’s Civil**

**Rights Coordinator** can be reached by calling the Member Services number on the back of your member ID card or by writing to the following address:

**Horizon BCBSNJ  
Civil Rights Coordinator  
PO Box 820, Newark, NJ 07101**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, through the Office for Civil Rights Complaint Portal, online at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail at

**U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201**or by phone at **1-800-368-1019**or **1-800-537-7697** (TDD). OCR Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.