



Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work.

SMALL GROUP ENROLLMENT/ CHANGE REQUEST

Mail to: Horizon BCBSNJ
Attn: Small Group Enrollment
P.O. Box 607 Department A
Newark, NJ 07101-0607

Email to: small_group_maintenance_enrollment_team@HorizonBlue.com
Fax (973) 274-2227
HorizonBlue.com

RESET

Group Information – to be completed by Employer.

Group Name: PRABHAV SERVICES INC. Group Number: 3756N
Sub Group Number: _____ Enrollment of a new Subscriber
Date of Hire: ____/____/____ Effective Date/Date of Event: ____/____/____
Reason for Change: _____

A. Type of Activity – to be completed by Employer.

Refer to instructions before completing this form. Print clearly.

<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE <input type="checkbox"/> OTHER CHANGE	Effective Date/Date of Event	Reason for Change
<input type="checkbox"/> Spouse	____/____/____	_____
<input type="checkbox"/> Civil Union Partner (CUP)	____/____/____	_____
<input type="checkbox"/> Domestic Partner (DP)	____/____/____	_____
<input type="checkbox"/> Dependent Child	____/____/____	_____
<input type="checkbox"/> Over-Age Child as a Dependent Under 31 (please complete Coverage Continuation section)	____/____/____	_____
<input type="checkbox"/> Name Change	____/____/____	_____
<input type="checkbox"/> Change Plan	____/____/____	_____
<input type="checkbox"/> Other	____/____/____	_____

COVERAGE CONTINUATION

For Employee Billing: Group
Date of Loss of Coverage: ____/____/____ Qualifying Event #** _____ Date of Qualifying Event: ____/____/____
 Total Disability* COBRA/NJSGC Length of Continuation (in months): 18 29
**Attach proof of disability*

For Spouse/Civil Union Partner*/Domestic Partner Billing: Group
Date of Loss of Coverage: ____/____/____ Qualifying Event #** _____ Date of Qualifying Event: ____/____/____
 COBRA/NJSGC Length of Continuation (in months): 18 29 36
**Civil union partners are eligible to make an election pursuant to NJSGC, if applicable.*

For Dependent or Over-aged Child
 COBRA/NJSGC Length of Continuation (in months): 18 29 36 Billing: Group
Date of Loss of Coverage: ____/____/____ Qualifying Event #** _____ Date of Qualifying Event: ____/____/____
 Dependent Under 31 Billing: Home
Date of Loss of Coverage: ____/____/____ Qualifying Event #** _____ Date of Qualifying Event: ____/____/____

Home Address: _____

**Qualifying event #: see list in Instructions.

B. Employee Information – to be completed by Employee.

ADD REMOVE CONTINUATION OTHER CHANGE
If a name change, indicate prior name: _____

Last Name, First Name, M.I. _____
Social Security # _____ Date of Birth ____/____/____ Sex _____
Home Address _____ Apt. _____ City _____ State _____ Zip Code _____
Home Phone _____ E-Mail Address _____
Employer Name PRABHAV SERVICES INC. Employment Date ____/____/____
Employer Address 181 NEW ROAD, STE. 304 City PARSIPPANY State NJ Zip Code 07054
Hours Worked Per Week _____ Work Phone 862-251-3528 E-Mail Address pushkar.shejwalkar@gmail.com
Primary Care Provider Name _____ Current Patient Yes No
NPI # _____ Loc Code _____
Other Health Coverage Yes No, If Yes, Payer Name _____
Policy # _____ Medicare ID #, If any _____
Dentist Office ID number (if applicable) _____ Current Patient Yes No

The Employee Copy of this application may be used as a temporary ID card for thirty days from the effective date if authorized by Employer. Coverage must be verified with Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc. prior to visiting a physician or admission to a hospital.

C. Race/Ethnicity – to be completed by the Employee, at his/her option.

NOTE: Your response is appreciated but NOT required! Choose a category that most closely describes you:

- American Indian or Alaskan Native
- Black, not of Hispanic origin
- Hispanic
- Asian or Pacific Islander
- White, not of Hispanic origin

D. Plan Option – to be completed by the Employee. Please refer to the Instructions for available continuation rights.

Medical Plan Option *Check One:*

- Horizon Advantage Direct Access
- PCMH Advantage EPO
- Horizon Advantage Direct Access (HSA)
- OMNIA
- Horizon Advantage EPO (HSA)
- OMNIA (HSA)
- Horizon Advantage EPO
- Other _____

Select one coverage option: S F H/W CUP DP P/C

Pediatric Dental and Family Pediatric Dental *Check One:*

- Horizon Young Grins (only provides benefits for members under 19)
- Horizon Family Grins
- Horizon Family Grins Plus

Select one coverage option: S F H/W CUP DP P/C

Family Dental *Check One:*

- Horizon Dental Option Plan
- Horizon Dental Choice
- Horizon Dental PPO
- Horizon Healthy Smiles
- Horizon Dental PPO Access
- Horizon Healthy Smiles Plus
- Horizon Dental Companion

Select one coverage option: S F H/W CUP DP P/C

Vision Plan Option *Check One:*

- Horizon Expanse V
- Horizon Panorama IV (Alt A)
- Horizon Vista II
- Horizon Expanse VII (Alt A)
- Horizon Panorama IV (Alt B)
- Horizon Vista III
- Horizon Expanse VII (Alt B)
- Horizon Vista IV
- Horizon Expanse VIII

Select one coverage option: S F H/W CUP DP P/C

S = Single F = Family H/W = Husband/Wife CUP = Civil Union Partners DP = Domestic Partners P/C = Parent/Child(ren)

E. Other Individuals Covered – to be completed by Employee.

Identify individuals other than yourself for whom you are adding/changing/removing/continuing coverage. Attach additional pages if necessary, with your signature and dated. Attach proof of disability.

- SPOUSE/CUP/DP** ADD REMOVE CONTINUE SPOUSE (COBRA/NJSGC)
 CONTINUE CU PARTNER (NJSGC) CONTINUE DP (NJSGC)

Last Name, First Name, M.I. _____

Social Security # _____ Date of Birth ____/____/____ Sex _____

Primary Care Provider Name _____ Current Patient Yes No

NPI # _____ Loc Code _____

Other Health Coverage Yes No, If Yes, Payer Name _____

Policy # _____ Medicare ID #, If any _____

Dentist Office ID number (if applicable) _____ Current Patient Yes No

Employed? Yes No *If yes, Complete Section F*

1. Child ADD REMOVE CONTINUATION OTHER CHANGE

Last Name, First Name, M.I. _____
Social Security # _____ Date of Birth ____/____/____ Sex _____
Primary Care Provider Name _____ Current Patient Yes No
NPI # _____ Loc Code _____
Other Health Coverage Yes No, If Yes, Payer Name _____
Policy # _____ Medicare ID #, If any _____
Dentist Office ID number (if applicable) _____ Current Patient Yes No
If last name is different from Employee's, please explain: _____
Living with Employee? Yes No *If No, Complete Section G*

2. Child ADD REMOVE CONTINUATION OTHER CHANGE

Last Name, First Name, M.I. _____
Social Security # _____ Date of Birth ____/____/____ Sex _____
Primary Care Provider Name _____ Current Patient Yes No
NPI # _____ Loc Code _____
Other Health Coverage Yes No, If Yes, Payer Name _____
Policy # _____ Medicare ID #, If any _____
Dentist Office ID number (if applicable) _____ Current Patient Yes No
If last name is different from Employee's, please explain: _____
Living with Employee? Yes No *If No, Complete Section G*

F. Additional Spouse/CUP/DP Information – to be completed by Employee. *If not applicable mark as N/A.*

1. Employer Name _____ Employer Phone _____
Employer Address _____
City _____ State _____ Zip Code _____

G. Additional Child Information – to be completed by Employee.

Provide information below about children listed in Section E, if they have a different address from the employee. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.

Name _____
Address _____ Apt _____
City _____ State _____ Zip Code _____
Reason: _____
Name _____
Address _____ Apt _____
City _____ State _____ Zip Code _____
Reason: _____

2. Child **ADD** **REMOVE** **CONTINUATION** **OTHER CHANGE**

Last Name, First Name, M.I. _____
Social Security # _____ Date of Birth ____/____/____ Sex _____
Primary Care Provider Name _____ Current Patient Yes No
NPI # _____ Loc Code _____
Other Health Coverage Yes No, If Yes, Payer Name _____
Policy # _____ Medicare ID #, If any _____
Dentist Office ID number (if applicable) _____ Current Patient Yes No
If last name is different from Employee's, please explain: _____
Living with Employee? Yes No *If No, Complete Section G*

F. Additional Spouse/CUP/DP Information – to be completed by Employee. If not applicable mark as N/A.

1. Employer Name _____ Employer Phone _____
Employer Address _____
City _____ State _____ Zip Code _____

G. Additional Child Information – to be completed by Employee.

Provide information below about children listed in Section E, if they have a different address from the employee. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.

Name _____
Address _____ Apt _____
City _____ State _____ Zip Code _____
Reason: _____
Name _____
Address _____ Apt _____
City _____ State _____ Zip Code _____
Reason: _____

H. Employee 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 Enrollment/Change Request form. I authorize deductions from my earnings for any contributions required from me.

Signature: X _____ Date: ____/____/____

I. Over-Age Child's Signature

I represent that all the information supplied in this application regarding the Dependent Under 31 Continuation Election is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I hereby agree to make premium payments required from me for the Dependent Under 31 Continuation Election.

Signature: _____ Date: ____/____/____

J. Employer Verification

The requested activity is believed eligible and is approved by the Employer.

Employer Representative: X _____ Date: ____/____/____

Representative's Title: _____