



Horizon Blue Cross Blue Shield of New Jersey

# ENROLLMENT/CHANGE REQUEST

## Horizon BCBSNJ Dental Programs

P.O. Box 1938  
Newark, NJ 07101-1938  
www.horizonblue.com/dental  
1-800-4DENTAL

### Group Information - To Be Completed by Employer

Group Name	Group Number	Subgroup Number

### A. Type of Activity - To Be Completed by Employer Refer to instructions on back before completing this form. Print clearly.

<b>1. Enrollment</b> <input type="checkbox"/> New Subscriber  <b>Effective Date</b> _____/_____/_____  <b>Date of Hire</b> _____/_____/_____ 	<b>2. Change - Check all that apply.</b> <input type="checkbox"/> Add Spouse/Domestic Partner <input type="checkbox"/> Add Dependent Child <input type="checkbox"/> Name Change <input type="checkbox"/> Change Plan <input type="checkbox"/> Other <input type="checkbox"/> Add/Change Dentist Office ID 	<b>3. Remove or Terminate - Check all that apply.</b> <input type="checkbox"/> Remove Spouse/Domestic Partner* <input type="checkbox"/> Remove Dependent Child* <input type="checkbox"/> Employee Withdrawal/Termination Note: Employee must be enrolled for spouse/dependent(s) to have coverage. *Please complete Add/Change/Remove and Name columns in Section D.	<b>4. Continuation of Coverage, i.e., COBRA, State, Total Disability</b> <i>Not all options are available. Contact Employer for available options.</i> Coverage For: <input type="checkbox"/> Employee <input type="checkbox"/> Dependents Length of Continuation: <input type="checkbox"/> 12 mos <input type="checkbox"/> 18 mos <input type="checkbox"/> 29 mos* <input type="checkbox"/> 36 mos <input type="checkbox"/> Total Disability Date of Loss of Coverage: _____/_____/_____ Date of Qualifying Event: _____/_____/_____ *Attach proof of disability
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### B. Employee Information - Complete Sections B - G

Social Security Number	Last Name, First Name, M.I.		Home Telephone ( )
Home Address	Apt. No.	City, State	ZIP Code
Employer Name	Work Telephone ( )		
Work Address	City, State	ZIP Code	
Date of Employment	Hours Worked		

### C. Plan Option - Your selection must be offered by your employer.

<b>Horizon BCBSNJ</b>	<b>Horizon Healthcare Dental</b>	<b>Contract Type</b>
<input type="checkbox"/> Horizon Dental Traditional	<input type="checkbox"/> *Horizon Dental Choice	<input type="checkbox"/> S - Single <input type="checkbox"/> F - Family
<input type="checkbox"/> Horizon Dental Option	<input type="checkbox"/> *Horizon TotalCare Dental	<input type="checkbox"/> H/W - Husband & Wife (or Domestic Partners)
<input type="checkbox"/> Horizon Dental PPO		<input type="checkbox"/> P/C - Parent & Child
<input type="checkbox"/> Horizon Dental PPO Access		
*Please select Dentist Office ID Number-Section D		

### D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. Attach proof if full-time college student. Attach proof of disability.

	(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex M F	Birthdate MM DD YYYY	Social Security Number	Other Dental Coverage Check if Yes	Dentist Office ID Number (if applicable)	Current Patient Check if Yes	Previous Coverage Check if Yes
Employee			<input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Spouse			<input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Domestic Partner*			<input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Child			<input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Child			<input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Child			<input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

\*Please attach proof of Domestic Partnership

### E. Other/Previous Insurance

Is your Spouse Employed?  Yes  No If "Yes," give name & address of spouse's employer.

If "Yes" to Other Dental Coverage (Section D), give name & policy number of insurance carrier, HMO, or other source.

If "Yes" to previous coverage, identify name(s) of person(s), give effective date and date coverage terminated, name of previous carrier and plan number and submit a copy of the Certificate of Credible Coverage issued by the previous carrier, if available.

### F. Dependent Information

Does any dependent listed in Section D live at a different address than the Employee?  Yes  No If "Yes," who and at what address?

Explain the circumstances.

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

### G. Employee Signature If you have any questions concerning the benefits and services provided by or excluded under this contract, contact a benefits representative at your company before signing this form.

I represent that all the information supplied in this enrollment/change request form is true and complete. I hereby agree to the conditions of enrollment on the reverse side of the employee copy of this enrollment/change request. I authorize deductions from my earnings for any required contribution.	Employee Signature - Required	
	X Date _____/_____/_____	E-Mail Address _____

### H. Employer Verification - To Be Completed by Employer

Employer Signature - Required	
X Title _____	Date _____/_____/_____

Employee copy may be used as a temporary ID card for 30 days from the effective date if authorized by employer. Coverage must be verified with Horizon BCBSNJ Dental Programs prior to visiting a specialist or admission to a hospital.

Nonmanaged products are issued by Horizon Blue Cross Blue Shield of New Jersey. Managed products are issued by Horizon Healthcare Dental, Inc., a subsidiary of Horizon Blue Cross Blue Shield of New Jersey. Each is an independent licensee of the Blue Cross Blue Shield Association. Administrative services are provided by Horizon Healthcare Dental Services, Inc.