



ENROLLMENT/CHANGE REQUEST

Horizon BCBSNJ Dental Programs

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

Horizon Blue Cross Blue Shield of New Jersey

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.

1. Enrollment <input type="checkbox"/> New Subscriber Effective Date _____/_____/_____ Date of Hire _____/_____/_____ 	2. Change - Check all that apply: <input type="checkbox"/> Add Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Civil Union 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 Date of Event Reason _____/_____/_____ _____ _____/_____/_____ _____ _____/_____/_____ _____ 	3. Remove or Terminate - Check all that apply: <input type="checkbox"/> Remove Spouse/Domestic Partner/ Civil Union Partner* _____/_____/_____ <input type="checkbox"/> Remove Dependent Child* _____/_____/_____ <input type="checkbox"/> Employee Withdrawal/Termination _____/_____/_____ Note: Employee must be enrolled for spouse/domestic partner/civil union partner/ dependent(s) to have coverage. *Please complete Add/Change/Remove and Name columns in Section D.	4. Continuation of Coverage, i.e., COBRA, State, Total Disability Not all options are available. Contact Employer for available options. Coverage For: <input type="checkbox"/> Employee <input type="checkbox"/> Dependents Length of Continuation: <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
---	---	---	---

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.

Horizon BCBSNJ	Horizon Healthcare Dental	Contract Type
<input type="checkbox"/> Horizon Dental Option	<input type="checkbox"/> *Horizon Dental Choice	<input type="checkbox"/> S - Single <input type="checkbox"/> F - Family
<input type="checkbox"/> Horizon Dental PPO	<input type="checkbox"/> *Horizon TotalCare Dental	<input type="checkbox"/> 2 Adults
<input type="checkbox"/> Horizon Dental PPO Access		<input type="checkbox"/> P/C - Parent & Child
*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)	NPI Number	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"/>
Civil Union 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"/>

E. Other/Previous Insurance

Is your Spouse/Domestic Partner/Civil Union Partner Employed? Yes No If "Yes," give name & address of spouse's/
 Domestic Partner's/Civil Union Partner'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 persons, 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.
 Services and products may be provided by Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare Dental, Inc., each of which is an independent licensee of the Blue Cross and Blue Shield Association. Horizon Healthcare Dental Inc., is a subsidiary of Horizon Blue Cross Blue Shield of New Jersey.