



Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work.



***51+ Group Application
(Medical/Rx)***

Horizon Blue Cross Blue Shield of New Jersey 51+ Group Application

Please Print - Shaded areas to be completed by Horizon BCBSNJ

Group Number _____ Effective Date _____	
Group name _____ Primary location: Street _____ City _____ State _____ ZIP code _____ Telephone number (____) _____ Fax number (____) _____	
ERISA Information: SIC code (4-digit) _____ Type of industry _____ ID cards mailed to: <input type="checkbox"/> Group <input type="checkbox"/> Employee's home Contract mailed to: <input type="checkbox"/> Group <input type="checkbox"/> Broker ERISA plan: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide the following information: ERISA plan year _____ ERISA plan number (3 digits) _____ Name of ERISA plan administrator _____ Title _____ Name of ERISA plan sponsor _____ Title _____ Funding: <input type="checkbox"/> Fully-insured <input type="checkbox"/> Self-insured Plan code number _____ Tax ID number _____	
Group Information: Group official: Name _____ Title _____ Telephone number (____) _____ Fax number (____) _____ E-mail _____ Group Administrator: Name _____ Title _____ Telephone number (____) _____ Fax number (____) _____ E-mail _____ Billing address: Street _____ City _____ State ____ ZIP code _____	
Group Enrollment Information: Number of employees: Eligible _____ Enrolled in plan _____ Employer contribution: Employee _____ Two Adults _____ Family _____ P/C _____ Open enrollment frequency: <input type="checkbox"/> Annually <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Other (explain) _____ _____ _____	
Group Eligibility Information: I. Waiting period and effective date New hires: First of the month following: <input type="checkbox"/> 1 month <input type="checkbox"/> 2 months <input type="checkbox"/> 3 months <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 180 days <input type="checkbox"/> Date of employment <input type="checkbox"/> Other (100+ enrolled groups only) _____ Date of hire: <input type="checkbox"/> Date of hire <input type="checkbox"/> 1 month <input type="checkbox"/> 2 months <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 120 days <input type="checkbox"/> Upon retirement <input type="checkbox"/> Other (100+ enrolled groups only) _____ Rehires: <input type="checkbox"/> Same as new hires <input type="checkbox"/> Date of rehire <input type="checkbox"/> Other (100+ enrolled groups only) _____	
II. Termination of employee: <input type="checkbox"/> Date of event <input type="checkbox"/> Last day of the month Class of eligible employees: (Check all that apply.) <input type="checkbox"/> Full-time <input type="checkbox"/> Full-time hours _____ <input type="checkbox"/> Retirees/pensioner <input type="checkbox"/> Part-time <input type="checkbox"/> Part-time hours _____	
III. Domestic Partners: <input type="checkbox"/> No (If yes, check one): <input type="checkbox"/> Same-sex <input type="checkbox"/> All <input type="checkbox"/> Other	

Union affiliation: No Yes, name of local _____

Comments _____

Current carrier(s) replaced _____

Member Maintenance Online Enrollment:

For a group to sign up for Member Maintenance directly, please go to <www.HorizonBlue.com>. Then click on *Online Services* and *Member Maintenance Registration*.

If third party/broker will be doing the administration of online enrollment, please complete the following:

Name _____

Title _____

E-mail Address _____

Please provide a signed third party agreement.

COBRA Elect:

Yes No

Workers' Compensation Carrier: _____

Method of Billing:

Traditional Minimum premium Premium lag Discounted premium ASC

Group Rates:

Product(s): HMO POS Direct Access PPO Indemnity Prescription drug

	Single	Two Adults	Family	P/C
Medical (_____): \$	\$_____	\$_____	\$_____	\$_____
Rx (_____): \$	\$_____	\$_____	\$_____	\$_____
Total	\$_____	\$_____	\$_____	\$_____
Medical (_____): \$	\$_____	\$_____	\$_____	\$_____
Rx (_____): \$	\$_____	\$_____	\$_____	\$_____
Total	\$_____	\$_____	\$_____	\$_____
Medical (_____): \$	\$_____	\$_____	\$_____	\$_____
Rx (_____): \$	\$_____	\$_____	\$_____	\$_____
Total	\$_____	\$_____	\$_____	\$_____

Remarks/Comments _____

Agent/Producer Information:

Broker signature _____ Date _____ Vendor number _____

Commission Information:

Commission of _____%.

Broker name _____ Name of agency _____

Telephone number (____) _____ Fax (____) _____

Street _____

City _____ State _____ ZIP code _____

E-mail address _____

Others (name, title) _____

I authorize the aforementioned Commissioned Broker to be the Broker of Record for our health insurance. This contract will be valid until Horizon Blue Cross Blue Shield of New Jersey is notified in writing to cancel. Commissions should be paid to our group's Broker of Record beginning on our effective/anniversary date.

Group name (print) _____

Group official's name (print) _____

Group official's signature _____ Date _____

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

For internal use only

Horizon BCBSNJ sales rep _____ Employee number _____

Underwriter _____