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Horizon Blue Cross Blue Shield of New Jersey

NJ Protect Enrollment Form

1. Please read the instructions on the back page before completing this enrollment form.

2. Please print clearly.

3. You must complete the Non-group Enrollment/Change Request Form and the Supplemental Enrollment Information Form.

4. You must sign and date both enrollment forms.

INSTRUCTIONS AND ELIGIBILITY REQUIREMENTS

Instructions

- All sections of the NJ Protect Non-Group Enrollment/Change Request Form (except for Section D.) and the NJ Protect Supplemental Enrollment Information Form must be **completed, signed and dated.** Separate forms must be completed for each person seeking coverage.
- Before mailing be sure you enclose:
  - ✓ Proof of residency in New Jersey
  - ✓ Proof of United States Citizenship, status as a national, or lawful presence in the United States
  - ✓ Certificate of Creditable Coverage (if any) or other proof of coverage termination
  - ✓ A bill for health care (if care was received within the last 6 months)
  - ✓ Evidence of payment of such health care bill (if care was received within the last 6 months)
  - ✓ Charity care or health center documentation (if any)
  - ✓ Documentation from a practitioner

  The above documentation will not be returned. The documentation from a practitioner must be the **original**. For all other documentation please keep your original and enclose photocopies.
- Please PRINT except when a signature is requested.
- You can obtain the providers' correct names and addresses from the appropriate provider directory. You may also obtain each provider's NPI number and LOC Code from the appropriate 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.
- For provider addresses, include the zip code plus the four-digit extension (11 digits.)
- "Previous Coverage" and "Other Health Coverage" includes coverage under a: group health plan resulting from employment, whether with a private or public (governmental) employer, including such coverage continued through a COBRA election or state continuation provisions; a church plan, Medicare, Medicaid, NJ FamilyCare or another individual health benefits plan.
- Your monthly premium payment is due at the time you submit this NJ Protect enrollment form to Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ). You can find your current monthly premium by looking at the enclosed rate sheet, contacting your Horizon BCBSNJ sales representative or by visiting our Web site <www.HorizonBlue.com>
- IF YOU HAVE ANY QUESTIONS concerning the benefits and services provided by or excluded under this policy, contact a Horizon BCBSNJ Sales representative at 1-888-551-2130 before signing this form.
- KEEP A COPY OF THIS COMPLETED APPLICATION! A copy of this application may be used as a temporary ID card for 30 days from the effective date if authorized by Horizon BCBSNJ or Horizon Healthcare of New Jersey, Inc. Coverage must be verified with Horizon BCBSNJ or Horizon Healthcare of New Jersey, Inc. prior to visiting with a physician or admission to a hospital.

Eligibility

A. You MUST be a U.S. citizen, OR a non-citizen national of the U.S., OR a legal alien. (Please enclose proof)

B. You MUST be a New Jersey resident. (Please enclose proof of residency- e.g., NJ driver's license, mortgage or rent bill, utility bill or a bank statement)

C. You MUST have been uninsured for at least 6 months prior to the date you apply for NJ Protect coverage. (Please enclose your Certificate of Creditable Coverage (if any) or other proof of prior coverage termination.)

D. You MUST have a prior pre-existing medical condition (Please include documentation from your practitioner.)

E. Your coverage will become effective on the 1st or the 15th of the month, whichever first occurs on or after the 10th day following our receipt of your completed application, required documentation and premium payment. You may request a later effective date however, the date must occur on the 1st or 15th of the month.

CONDITIONS OF ENROLLMENT – APPLICANT ACKNOWLEDGES AND AGREEMENTS

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 BCBSNJ, or Horizon Healthcare of New Jersey, Inc., or any consumer reporting agency acting on behalf of Horizon BCBSNJ or Horizon Healthcare of New Jersey, Inc. information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me. 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 or Horizon Healthcare of New Jersey, Inc., 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 or Horizon Healthcare of New Jersey, Inc. will provide coverage in accordance with the terms of the contract for the individual plan.
5. I understand that my enrollment in Horizon BCBSNJ or Horizon Healthcare of New Jersey, Inc.'s NJ Protect Plan is effective upon acceptance by Horizon BCBSNJ or Horizon Healthcare of New Jersey, Inc.
6. 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 individual policy if premiums are not paid timely.

Misrepresentations

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

Horizon Blue Cross Blue Shield of New Jersey

NJ PROTECT NON-GROUP ENROLLMENT/CHANGE REQUEST FORM

Attn: Consumer Enrollment Dept.
P.O. Box 1330
Newark, NJ 07101-1330
www.HorizonBlue.com

A. Type of Activity – to be completed by Applicant

1. ADD Effective Date/Date of Event Reason

☐ Enrollment of a new Subscriber _____/_____/_____ _____

2. OTHER CHANGE Effective Date/Date of Event Reason Effective Date/Date of Event Reason

☐ Name Change _____/_____/_____ _____ ☐ Add/Change Office ID Numbers: Primary Care Provider _____/_____/_____ _____

☐ Change Plan _____/_____/_____ _____ ☐ Other _____ _____/_____/_____ _____

B. Applicant Information

☐ Add ☐ Other Change ☐ Continue *If a name change, indicate prior name:* _____

Last Name: First Name: MI:

Social Security #: Date of Birth: MM DD YYYY Sex: M F

Are you a resident of New Jersey? ☐ Yes ☐ No

Primary Residence: Street Apt.:

City: State: Zip Code: Home Phone: E-Mail Address:

Do you maintain a home in any other state? ☐ Yes ☐ No *If yes:* Name of State: _____ Number of months you live there each year: _____

Other Residence: Street Apt.:

City: State: Zip Code: Home Phone:

Your billing address: ☐ Primary residence ☐ Other residence ☐ P.O. Box or Other *(specify)*: _____

Primary Care Provider Name: Current Patient: ☐ Yes ☐ No

Primary Care Provider Address:

City: State: Zip Code + 4: —

NPI #: Loc Code:

Are you covered under Other Health Coverage? ☐ Yes ☐ No *If yes:* Payer Name: _____

Policy #: Medicare ID#, if any:

Why are you applying for individual coverage? _____ Are you **eligible but not covered** under Other Health Coverage? ☐ Yes ☐ No *If yes, what is it?*

☐ Group plan via employment *(specify payer)*: _____ ☐ Medicaid/NJFamilyCare ☐ Medicare ☐ Other *(specify)*: _____

Previous Coverage? ☐ Yes ☐ No *If yes:* Payer Name; _____

Policy #: Effective Date: MM DD YYYY Termination Date: MM DD YYYY

C. Plan Option *(Single Coverage Only)*

Check one: ☐ NJ Protect 80/70 ☐ NJ Protect 100/70

D. Race/Ethnicity *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

E. Payment Information *Indicate how you would like to make payment*

☐ Check ☐ Money Order ☐ Automatic Bank Draft (attach voided check) ☐ Credit Card Type (☐ Visa ☐ Mastercard)

Credit Card No.: _____ Exp. Date: _____/_____ Cardholder Name: _____

F. Applicant's 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.

Signature: _____ Date: _____/_____/_____

G. Horizon BCBSNJ Representative's Signature

Signature: _____ Date: _____/_____/_____

YOU MUST ALSO COMPLETE THE NJ PROTECT SUPPLEMENTAL ENROLLMENT INFORMATION FORM.

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NJ PROTECT SUPPLEMENTAL
ENROLLMENT INFORMATION FORM

A. Applicant Information

Last Name: | First Name: | MI:

Social Security #: | Date of Birth: MM DD YYYY

Residence Address: Street | Apt.:

City: | State: | Zip Code:

Enclose proof of residency in New Jersey

Employer's Name (if not employed, state none)

Does your employer offer health coverage? ☐ Yes ☐ No *If **yes**,* explain why you are not covered under the employer's plan.

B. Citizenship

Are you a citizen of the United States? ☐ Yes ☐ No
If yes, please enclose a copy of your birth certificate, U.S. passport, certificate of citizenship or a copy of your naturalization certificate.

Are you a noncitizen national of the United States? ☐ Yes ☐ No
If yes, please enclose a copy of your U.S. passport that shows national status.

If No to both of the above, are you lawfully present in the United States? ☐ Yes ☐ No
If yes, please enclose a copy of your immigration documents including at least one that has your Alien Registration Number or I-94 number.

C. Prior Health Coverage

Within the past 6 months were you covered under any health plan? ☐ Yes ☐ No

Coverage under a health plan includes coverage you may have bought on your own, coverage from an employer covering you as an employee or as a dependent, coverage under continuation such as COBRA or State continuation, coverage under Medicare, Medicaid, NJ FamilyCare, TriCare or coverage under a public health plan established or maintained by a foreign country or political subdivision.

If **yes**, when did the health coverage end? _____

Why did the coverage end? _____

Please enclose the Certificate of Creditable Coverage.

If **no**, what was the last date you had health coverage? _____

Please enclose any documentation you may have to show when the prior coverage ended.

If you have received health care during the past 6 months please enclose:

a. A copy of a bill for health care. ***b. Evidence of your payment of such bill.***

If you accessed care at a Health Center or Charity Care in a Hospital enclose documentation of such care.

D. Pre-Existing Conditions

For purposes of the NJ Protect coverage a ***pre-existing condition*** is defined as: Medical conditions clinically present prior to the date of coverage, whether or not symptomatic or treated, and whether or not currently symptomatic or in a state of remission, for which treatment has been or will be medically necessary and appropriate.

Have you been diagnosed or treated for a pre-existing condition? ☐ Yes ☐ No

If yes, list the condition(s). _____

Enclose documentation of the condition from the practitioner who diagnosed or treated the condition. The documentation must:

a. state the name of the patient
b. list the date(s) of visits within the past 6 months
c. name the condition for which diagnosis or treatment was provided
d. be dated and signed by the practitioner within the past 6 months, and
e. include the practitioner's license number.

E. Premium Payment

If approved will you be paying the health coverage premiums using personal funds? ☐ Yes ☐ No If no, who will be paying the premiums?_____

F. Effective Date

The effective date of coverage will be the 1st or 15th of the month whichever first occurs on or after the 10th day following our receipt of the completed application, required documentation and premium payment.

G. Signature

I represent that all of the information contained in this Supplemental Enrollment Information Form is true and complete.
I understand that if I become covered under Medicare or under a group plan I will be required to promptly notify Horizon BCBSNJ of my coverage.

I authorize Horizon BCBSNJ to provide HMS with my Applicant Information as contained on this Supplemental Enrollment form. I understand HMS is a vendor with a database of health plan data and that this data will be used to verify my prior health coverage information.

Signature: _____ Date: _____

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