

ENROLLMENT/CHANGE REQUEST

Horizon BCBSNJ Vision Plan

www.horizonblue.com

www.davisvision.com

Group Information - To Be Completed by Employer

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

Group Name	Group Number	Subgroup Number
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1. Enrollment <input type="radio"/> New Subscriber Effective Date ____/____/____ Date of Hire ____/____/____	2. Change - Check all that apply. Date of Event Reason <input type="radio"/> Add Spouse <input type="radio"/> Domestic Partner <input type="radio"/> Civil Union Partner ____/____/____ <input type="radio"/> Add Dependent Child ____/____/____ <input type="radio"/> Name Change ____/____/____ <input type="radio"/> Change Plan ____/____/____ <input type="radio"/> Other ____/____/____	3. Remove or Terminate - Check all that apply. Effective Date Reason <input type="radio"/> Remove Spouse/Domestic Partner/ Civil Union Partner* ____/____/____ <input type="radio"/> Remove Dependent Child* ____/____/____ <input type="radio"/> 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="radio"/> Employee <input type="radio"/> Dependents Length of Continuation: <input type="radio"/> 18 mos <input type="radio"/> 29 mos* <input type="radio"/> 36 mos <input type="radio"/> 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

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

Social Security Number	Last Name, First Name, M.I.	Home Telephone () - - - - -
Home Address		ZIP Code
Employer Name		Work Telephone () - - - - -
Work Address		ZIP Code
Date of Employment	Hours Worked	

Horizon Panorama III III Alt B	Contract Type <input type="radio"/> S - Single <input type="radio"/> F - Family <input type="radio"/> 2 Adults <input type="radio"/> P/C - Parent & Child
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D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children.

	A)dd C)hange R)emove	Last Name, First Name, M.I.	Sex		Birthdate			Social Security Number					
			M	F	MM	DD	YYYY						
Employee			<input type="radio"/>	<input type="radio"/>	/	/							
Spouse			<input type="radio"/>	<input type="radio"/>	/	/							
Domestic Partner			<input type="radio"/>	<input type="radio"/>	/	/							
Civil Union Partner			<input type="radio"/>	<input type="radio"/>	/	/							
Child			<input type="radio"/>	<input type="radio"/>	/	/							
Child			<input type="radio"/>	<input type="radio"/>	/	/							
Child			<input type="radio"/>	<input type="radio"/>	/	/							

E. Dependent Information

Does any dependent listed in Section D live at a different address than the Employee? <input type="radio"/> Yes <input type="radio"/> No If "Yes," who and at what address? If any dependent's last name differs from yours, explain the circumstances.	Explain the circumstances.
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F. Employee Signature _____ **Date** _____

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.

G. Employer Verification - To Be Completed by Employer

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	Employee Signature - Required
	<input checked="" type="checkbox"/> Date ____/____/____	<input checked="" type="checkbox"/> Title _____