County of Monmouth Medical Enrollment/Change Form

A. Employee Information Please read and complete the entire form. If you are making changes, please check box in part B. Even if you have no changes, read, complete and sign the form.

Last Name	First Name and Middle Initial	Social Security #	Date of Birth	Marital Status (select one) Single ☐ Married ☐ Civil Union ☐ Divorced/Separated ☐
Street Address	Apt # / City / State			ZIP Code / Email address (if available) / Union Name (if applicable)
Home Telephone ( )	Work Telephone ( )	Full-Time Hire Date	Hrs Worked Per Week / Effective Date	B. Coverage or Enrollment Change-Important! ☐ Check this box if you are making any enrollment or plan changes since your last enrollment.

C. Individuals Covered - List individuals for whom you are requesting coverage. Attach a sheet to list additional children.

Last Name, First Name, M.I.	Relationship to employee	(A)dd (C)hange (R)emove (K)eep	Date of Birth (MM/DD/YY)	Social Security Number	Gender M F	Other Health Coverage (9 if Yes)	Primary Care Physician Info: PCP Office ID Number*	PCP Name (Last Name, First)	PCP Office Location (city/town)	Current Patient? (9 if Yes)
	Employee				☐ ☐	◯				☐
	Spouse/Civil Union Partner				☐ ☐	◯				☐
	Child				☐ ☐	◯				☐
	Child				☐ ☐	◯				☐
	Child				☐ ☐	◯				☐
	Child				☐ ☐	◯				☐

*For Horizon BCBS PCP information, visit www.Horizonblue.com, quick physician search; choose the Direct Access network for NJ Providers. For QualCare, please go to www.Qualcareinc.com, & click on providers on the top right.

D. Plan Option & Coverage Level Selection

Carrier and Plan Selection	Check Box (select one)	Coverage Level Selection From		To	
Horizon Direct Access PPO	☐	Employee Only	☐	Employee Only	☐
Horizon Value Plan	☐	Employee + 1 (Spouse or CU Partner)	☐	Employee + 1 (spouse or CU Partner)	☐
QualCare HMO	☐	Employee and Child(ren)	☐	Employee and Child(ren)	☐
Horizon OMNIA	☐	Family	☐	Family	☐
Waive Benefits	☐				

E. Other Insurance

1. Is your Spouse/Civil Union Partner Employed? ☐ Yes ☐ No If Yes, provide name & address of his or her employer.

2. If "Yes" to Other Health Coverage (Section C), provide name & policy number of insurance carrier, HMO, or other source. Explain the circumstances.

3. If anyone listed on this enrollment form are enrolled in Medicare Parts A, B and/or D identify the coverage and provide the Medicare ID#.

F. Dependent Information

1. Does any dependent listed in Section C live at a different address than the employee? ☐ Yes ☐ No
If "Yes," who and what address? Explain the circumstances.

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

G. Employee Signature I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions on the reverse side/page 2 of this enrollment form.	Employee Signature – Required X Date: / /	Employer Verification X Date: / /	Horizon Enrollments Only Group Number-86260 Sub-Group number_____

Employee – Complete Sections A – G

Section A – Employee Information:

Complete all information to order for your application to be processed.

Section B – Plan or Demographic Change Indicator:

Check this box if you are making any plan or enrollment changes since your last enrollment

Section C – Individuals Covered:

- x Print name(s) of your dependent(s), if applicable under the appropriate relationship. Circle whether spouse or civil union partner.
- x Add/Change/Remove/Keep – Use "A", "C", "R" or "K" to indicate whether you are adding, changing, removing, or keeping coverage for an individual.
- x Indicate Gender, Date of Birth, and Social Security Number for each individual listed.
- x Complete PCP information for all members including the employee.
- x If you or your dependent(s) have other Health or Rx drug coverage check off the "Yes" box(es) and complete Section E – Other Insurance at the bottom of the form

Note: If a dependent is disabled and being continued beyond the limiting age of 26, attach proof of disability.

- x From the appropriate provider directory or on-line, locate the PCP office ID number for the primary care physician. Indicate office ID selection(s) on the form and list PCP's name and location.
- x If you are a current patient, please check "Current patient" box.

Section D – Plan Option and Coverage Level Selection:

- x Select Carrier and Plan Option
- x Indicate coverage level prior to 10/1/09 and after 10/1/09. This answer may or may not be the same depending upon if you have enrollment changes or not.

Section E – Other Insurance:

- x If you are including coverage for your spouse or civil union partner, answer question 1 regarding his or her employment status.
- x Answer questions 2 and/or 3 if you have indicated other health or rx coverage in section C.

Section F – Dependent Information:

- x Answer question 1 regarding dependents listed in Section C.
- x Answer question 2 if dependents have different last names than your own.

Section G – Employee Signature:

- x Read the acknowledgement and agreements section on the right side of this page
- x Employee must sign and date in order for the form to be processed.
- x Signature indicates agreement to terms and attests to complete, accurate, and true information.

Employee Acknowledgement and Agreements

On behalf of myself and the dependents listed on the reverse side/page1, I agree to or with the following:

1. a.) I authorize the sources stated below to give Horizon BCBSNJ or Horizon Healthcare of New Jersey, Inc., QualCare, IAA or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage, and medical advice, treatment or supplies for any physical or mental condition. Authorized sources are: any physician or medical professional; any hospital clinic or other medical care institution; any carrier; any consumer reporting agency; any employer.
   b.) I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which QualCare, IAA, Horizon BCBSNJ or Horizon Healthcare or New Jersey, Inc. has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
   c.) I know that I have a right to receive a copy of this authorization if I request one.
   d.) I agree that a photocopy of this authorization is as valid as the original.
2. I acknowledge by enrolling in a QualCare, IAA, Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) or Horizon Healthcare of New Jersey, Inc. plan coverage is provided by in accordance with the contract.
3. Enrollment of myself and of the listed dependents into the plan is effective on acceptance by QualCare, IAA, Horizon BCBSNJ or Horizon Healthcare of New Jersey, Inc.
4. I understand that my employer may request proof of dependent eligibility from time to time and I agree to provide appropriate documentation as requested.
5. I agree to inform my employer of any changes of dependent eligibility status within 30 days of a status change.

Misrepresentation

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

Employee healthcare deductions are automatically taken on a pretax, Section 125 plan basis to enable employees to take advantage of the obvious tax advantages. If for some reason, you would prefer not to have the deduction taken on a pretax basis, please call the Monmouth County Benefits Department at 732-866-3622 ext 7655, or 732-866-3622 ext 6671.

Waiver of Insurance Coverage

Notice of Special Enrollment Period

- x If you are declining enrollment for yourself and/or your eligible dependent(s) because of other health insurance coverage, or if you lose coverage, you may in the future be able to enroll yourself and/or your eligible dependent(s) in this plan, provided that you request enrollment within 30 days after your other coverage ends. If you are declining coverage for yourself and/or your eligible dependent(s) for any other reason, you cannot join the plan later unless you have a new dependent as a result of marriage, birth, adoption, placement for adoption, or during open enrollment period, if applicable. You may then be able to enroll yourself and your eligible dependent(s), provided that you request enrollment within 30 days after the marriage birth, adoption, or placement for adoption.
- x If you decline coverage for yourself and/or your eligible dependent(s) because of other health/dental coverage and you fail to fill out the front of this form concerning your (and/or your eligible dependent's) other coverage or if you fail to request plan enrollment within 30 days after your (and/or your eligible dependent's) other coverage ends, you will not be eligible to enroll yourself, or your eligible dependent(s) during the special enrollment period discussed above and you will need to wait until the next open enrollment period to enroll in the plan's health/dental coverage.