Horizon.

Horizon Blue Cross Blue Shield of New Jersey

VISION GROUP ENROLLMENT/CHANGE REQUEST

Mail to: Horizon BCBSNJ
Attn: Large and Mid-Size Group Enrollment
P.O. Box 10168
Newark, NJ 07101-3168
Email to: Midmajor_enrollment@horizonblue.com
Fax to: (973) 274-2257
HorizonBlue.com

A. Group Information – to be completed by Employer

Group Name: _____ Group Number: _____

Sub Group Number: _____ Date of Hire: ____/____/____ Effective Date/Date of Event: ____/____/____

B. Employee Information – to be completed by Employee

☐ ADD ☐ REMOVE ☐ CONTINUATION ☐ OTHER CHANGE

If a name change, indicate prior name: _____

Last Name, First Name, M.I. _____ Date of Birth ____/____/____ Sex _____

Social Security # _____ Apt. _____ City _____ State _____ Zip Code _____

Home Address _____ E-Mail Address _____

Home Phone _____ Employment Date ____/____/____

Employer Name _____

Vision *Check One:* ☐ S ☐ F ☐ 2 Adults ☐ PC

☐ Horizon Expanse V ☐ Horizon Panorama III - ALT. A ☐ Horizon Panorama IV - ALT. A ☐ Horizon Vista I

☐ Horizon Expanse VI ☒ Horizon Panorama III - ALT. B ☐ Horizon Panorama III - ALT. B ☐ Horizon Vista II

☐ Horizon Expanse VII-A ☐ Horizon Vista III

C. Other Individuals Covered – to be completed by Employer

Identify individuals other than yourself for whom you are adding/changing/removing/continuing coverage. Attach additional pages if necessary, with your signature and dated. Attach proof of disability.

1. SPOUSE/CUP/DP ☐ ADD ☐ REMOVE ☐ CONTINUE SPOUSE (COBRA/NJSGC)
☐ CONTINUE CU PARTNER (NJSGC) ☐ CONTINUE DP (COBRA/NJSGC) ☐ OTHER CHANGE

Last Name, First Name, M.I. _____ Date of Birth ____/____/____ Sex _____

Social Security # _____ Current Patient ☐ Yes ☐ No

Primary Care Provider Name _____ Loc Code _____

NPI # _____

Other Health Coverage ☐ Yes ☐ No, If Yes, Payer Name _____

Policy # _____ Medicare ID #, If any _____

Home or billing address same as Employee? ☐ Yes ☐ No *If No, Complete Section F2*

2. Child ☐ ADD ☐ REMOVE ☐ CONTINUATION ☐ OTHER CHANGE

Last Name, First Name, M.I. _____ Date of Birth ____/____/____ Sex _____

Social Security # _____ Current Patient ☐ Yes ☐ No

Primary Care Provider Name _____ Loc Code _____

NPI # _____

Other Health Coverage ☐ Yes ☐ No, If Yes, Payer Name _____

Policy # _____ Medicare ID #, If any _____

If last name is different from Employee's, please explain: _____

Living with Employee? ☐ Yes ☐ No *If No, Complete Section G*

3. Child ☐ ADD ☐ REMOVE ☐ CONTINUATION ☐ OTHER CHANGE

Last Name, First Name, M.I. _____ Date of Birth ____/____/____ Sex _____

Social Security # _____ Current Patient ☐ Yes ☐ No

Primary Care Provider Name _____ Loc Code _____

NPI # _____

Other Health Coverage ☐ Yes ☐ No, If Yes, Payer Name _____

Policy # _____ Medicare ID #, If any _____

If last name is different from Employee's, please explain: _____

Living with Employee? ☐ Yes ☐ No *If No, Complete Section G*

dditional Spouse/CUP/DP Information – to be completed by Employee. *If not applicable mark as N/A*

:mployer Name _____ Employer Phone _____

:mployer Address _____

:ity _____ State _____ Zip Code _____

lome Address _____ Apt _____

:ity _____ State _____ Zip Code _____

Please explain why the address is different: _____

dditional Child Information – to be completed by Employee.

ride information below about children listed in Section E, if they have a different address from the employee. If multiple children are at ddress, you may list them together. Attach additional pages as necessary, signed and dated.

ne _____

ress _____ Apt _____

_____ State _____ Zip Code _____

son: _____

ne _____

ress _____ Apt _____

_____ State _____ Zip Code _____

son: _____

mployee Signature

resent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth is Enrollment/Change Request form. I authorize deductions from my earnings for any contributions required from me.

nature: _____ Date: _____/_____/_____

ver-Age Child's Signature

resent that all the information supplied in this application regarding the Dependent Under 31 Continuation Election is true and complete.
reby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form.
reby agree to make premium payments required from me for the Dependent Under 31 Continuation Election.

nature: _____ Date: _____/_____/_____

mployer Verification

requested activity is believed eligible and is approved by the Employer.

loyer Representative: _____ Date: _____/_____/_____

resentative's Title: _____