ENROLLMENT/CHANGE REQUEST
Horizon BCBSNJ Vision Plan

www.horizonblue.com
www.davisvision.com

Group Information - To Be Completed by Employ

Group Name	Group Number	Subgroup Number

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

1. Enrollment
O New Subscriber

Effective Date
______/______/_

Date of Hire
______/______/_

2. Change - Check all that apply. Date of Event Reason
O Add Spouse
O Domestic Partner
O Civil Union Partner ___/___/_
O Add Dependent Child ___/___/
O Name Change ___/___/_
O Change Plan ___/___/_
O Other ___/___/_

3. Remove or Terminate - Check all that apply.
Effective Date Reason
O Remove Spouse/Domestic Partner/
Civil Union Partner* ____/____/_
O Remove Dependent Child* ____/____/_
O 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: O Employee O Dependents
Length of Continuation: O 18 mos O 29 mos* O 36 mos
O Total Disability
Date of Loss of Coverage: ____/____/____ Date of Qualifying Event: /____/_
*Attach proof of disability

B. Employee Information - Complete Sections B – G

Social Security Number	Last Name, First Name, M.I.		Home Telephone ( )
Home Address	Apt. No.	City, State	ZIP Code
Employer Name			Work Telephone ( )
Work Address		City, State	ZIP Code
Date of Employment		Hours Worked	

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

Horizon Panorama III III Alt B

Contract Type
O S - Single O F - Family
O 2 Adults
O P/C - Parent & Child

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 M F	Birthdate MM DD YYYY	Social Security Number					
Employee			O O	/ /						
Spouse			O O	/ /						
Domestic Partner			O O	/ /						
Civil Union Partner			O O	/ /						
Child			O O	/ /						
Child			O O	/ /						
Child			O O	/ /						

E. Dependent Information

Does any dependent listed in Section D live at a different address than the Employee? O Yes O No If "Yes," who and at what address?	Explain the circumstances.
If any dependent's last name differs from yours, explain the circumstances.	

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 X		Employer Signature - Required X	
Date / /	E-Mail Address	Title	Date / /

Instructions

Employer

- Complete the **Employer Group Information** in the upper right corner of the form.
- **Section A - Type of Activity:** Check box(es) indicating reason(s) for submitting The Enrollment Change Request Form.
  If reason is other then indicated check **other** in box 2 and provide reason (i.e., rehire, open enrollment, newly eligible or previously refused/waived coverage).
- Complete **Section G - Employer Verification** in the lower right corner of the form.
  - Employer must complete this section for all new enrollments, coverage changes and terminations**.**

Employee - Complete Sections B - F

Section B - Employee Information:

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

Section C - Plan Option:

- Check one Plan Option box, indicate Plan Option Name (where applicable).
- Select only an option offered by your employer.

- Select Contract Type: **S**-Single, **F**-Family, **2**-Adults (Husband/Wife, Domestic Partner or Civil Union Partner), **P/C**-Parent & Child

Section D - Individuals Covered:

- Add/Change/Remove - Use “A”, “C”, or “R” to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.

Section E - Dependent Information:

Complete this section for all new enrollments or coverage changes.

Section F - Employee Signature:

- Employee must sign and date the Enrollment/Change Request Form in order for it to be processed.

Section G - Employer Verification:

- Employer must complete this section for all new enrollments, coverage changes and terminations.
- Employer must sign and date the Enrollment/Change Request Form in order for it to be processed.

Employee Acknowledgements and Agreements

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

1. a) I authorize the sources stated below to give to Horizon BCBSNJ, or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health 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 Horizon BCBSNJ 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 Horizon BCBSNJ vision program, coverage is provided by Horizon BCBSNJ in accordance with the contract.

3. Enrollment of myself and of the listed dependents into the plan is effective on acceptance by Horizon BCBSNJ.

4. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. My employer is hereby authorized to withhold payments from my wages, as appropriate.

Misrepresentation

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