Horizon Blue Cross Blue Shield of New Jersey

Dental Programs
P.O. Box 1938
Newark, NJ 07101-1938
www.HorizonBlue.com/dental
1-800-4DENTAL

Group Application for 51 + Employees

Group Number ______________________________ Effective Date: ______________

Company Name: ______________________________

Primary Location: ______________ (Street) ______________ (City) ______ (State) ______ (Zip)

Telephone Number: (___)______________ Fax Number: (___)______________ SIC Code (4-Digit): __________

Type of Industry: ______________________________ ID Cards Mailed to: ☐ Group ☐ Employee's Home

Company Official: Name ______________________ Title: ______________ Phone#: __________

Billing Contact: Name ______________________ Title: ______________ Phone#: __________

Number of Employees: Eligible ______________ Enrolled in Plan ______________

Employer Contribution:

Employee ________

Employees and Dependents (daughter/son/spouse/domestic partner/civil union partner) _______

Dependent Child(ren) covered to age: ______ (eom/eoy) Full-time Students covered to age: _____ (eom/eoy)

Probationary Period and Effective Date:

New Hires: Date of Hire ____________ # of Months __________ Effective Date ☐ 1st of month following

☐ Exact Date

☐ Other ______________

Rehires: Date of Hire ____________ ☐ Same as New ☐ Other ______________________

Termination of Employee: ☐ Exact Date ☐ End of Month

Class of Eligible Employees: *(Check all that apply.)*

☐ Full Time/# Hours per week ______ ☐ Permanent Part Time/# hours per Week ______

Salaried ______ and/or Hourly ________

Union Affiliation: ☐ Yes, Local # ______________________ ☐ No

Current Carrier Replaced: ______________________________

1. Is Horizon BCBSNJ's Internet maintenance for enrollment of interest to you?: ☐ Yes ☐ No
2. If yes, please provide email address for Internet contract: ______________________
3. Who will administer COBRA?: ☐ Group ☐ COBRA Elect ☐ Other ______________
4. Are retirees eligible for dental benefits?: ☐ Yes Required minimum number of years worked: __________ ☐ No
5. Amount of advanced check, if any: $ ________________ Check #: ________________
6. Is group in-force with HBCBSNJ for medical?: ☐ Yes ☐ No Group # ______________

If yes, please provide the following information as it relates to the medical Plan:

Dependents covered to age: __________ (eom/eoy) Full-time students covered to age: ____________ (eom/eoy)

Services and products may be provided by Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare Dental, Inc., each of which is an independent licensee of the Blue Cross and Blue Shield Association. Horizon Healthcare Dental Inc., is a subsidiary of Horizon Blue Cross Blue Shield of New Jersey.

Agent/Producer Information (This information must be answered completely.)

Broker Signature: ________________________________ Date: __________ Vendor Number: ______________

Commission Information:

- Commission of ____________%

Broker Name: ________________________________ Name of Agency: ______________________________

Telephone Number: (___)______________ Fax: (___)______________ E-mail Address: ____________________

Address: ________________________________ ________________________ ________ ________
Street *City* *State* *Zip*

Others: Name ____ Title ______________________________

Special Instructions: ____

Company Name: ____

Address: ________________________________ ________________________ ________ ________
Street *City* *State* *Zip*

Company Official's Signature ____ Date ________________

I authorize the aforementioned Commissioned Broker to be the Broker of Record for our health insurance. This contract will be valid until Horizon Blue Cross Blue Shield of New Jersey is notified in writing to cancel. Commissions should be paid to our company's Broker of Record beginning on our effective/anniversary date.