

Paying Your Plan Premium:

For Horizon Medicare Blue Value w/Rx Standard only:
If we determine that you owe a late enrollment penalty,
we need to know how you would prefer to pay it.

You can pay your monthly plan premium by mail each
month or make a payment by phone. You can also
choose to pay your premium by automatic deduction
from your Social Security check each month.

If you qualify for extra help with your Medicare
prescription drug coverage costs, Medicare will pay
all or part of your plan premium. If Medicare pays only
a portion of this premium, we will bill you for the
amount that Medicare does not cover. If you don't select
a payment option, you will receive a bill each month.

Please select a premium payment option:

- Receive a bill.
- Pay by Phone. You can also call Customer Service
to make a payment by phone using your checking
account. You will need to provide your routing
number and checking account number that are
provided at the bottom of your checks.
- Automatic deduction from your monthly Social
Security benefit check. (The Social Security
deduction may take two or more months to begin.
In most cases, the first deduction from your Social
Security benefit check will include all premiums
due from your enrollment effective date up to the
point withholding begins.)

Please Read and Answer These Important Questions:

1. Do you have End-Stage Renal Disease (ESRD)?

Yes No

If you answered yes to this question and you do
not need regular dialysis anymore, or have had a
successful kidney transplant, **please attach a note or
records** from your doctor showing you do not need
dialysis or have had a successful kidney transplant.

2. Some individuals may have other drug coverage,
including other private insurance, TRICARE, Federal
employee health benefits coverage, VA benefits, or
State pharmaceutical assistance programs.

Will you have other prescription drug coverage in
addition to Horizon Medicare Blue Value or Horizon
Medicare Blue Access?

Yes No

If yes, please list your other coverage and your
identification (ID) number(s) for this coverage:

Name of other coverage: _____

ID # for this coverage: _____

Group # for this coverage: _____

3. Are you a resident in a long-term care facility, such
as a nursing home?

Yes No

If yes, please provide the following information:

Name of institution: _____

Address and phone number of institution
(number and street): _____

4. Are you enrolled in your State Medicaid program?

Yes No

If yes, please provide your Medicaid number:

5. Do you or your spouse work? Yes No

Please choose the name and the J code of a Primary
Care Physician (PCP) from our provider directory.

HMO-required: If you do not select a PCP, one will
be assigned to you.

POS-optional: If you do not select a PCP, the higher
doctor office visit copay will apply.

Name: _____

J code: _____

Please check one of the boxes below if you would
prefer us to send you information in a language other
than English or in another format:

Spanish

Audio Tape or Large Print

Please contact Horizon Healthcare of New Jersey, Inc. at
1-800-224-1234 (TTY users should call 1-800-852-7899)
if you need information in another format or language
than what is listed above. Our office hours are Monday
through Friday, 8:30 a.m. to 5:00 p.m. EST.

Please Read This Important Information



If you currently have health coverage from an employer or union, joining one of our MA-PD plans could affect your employer or union health benefits. If you have health coverage from an employer or union, joining one of our MA-PD plans may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please Read and Sign Below:

By completing this enrollment application, I agree to the following:

Horizon Healthcare of New Jersey, Inc. plans are Medicare Advantage plans and have a contract with the Federal government. I will need to keep my Parts A & B. I can be in only one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I do not have Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.

Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: November 15 - December 31 of every year), or under certain special circumstances.

Horizon Healthcare of New Jersey, Inc. serves a specific service area. If I move out of the area that Horizon Healthcare of New Jersey, Inc. serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Horizon Healthcare of New Jersey, Inc., I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Horizon Healthcare of New Jersey, Inc. when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Horizon Healthcare of New Jersey, Inc. coverage begins, I must get all of my health care from Horizon Healthcare of New Jersey, Inc., with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by Horizon Healthcare of New Jersey, Inc. and other services contained in my Horizon Healthcare of New Jersey, Inc. Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HORIZON HEALTHCARE OF NEW JERSEY, INC. WILL PAY FOR THE SERVICES.** I understand that if I am receiving assistance from a sales agent, broker or other individual employed by or contracted with Horizon Healthcare of New Jersey, Inc. he/she may be compensated based on my enrollment in Horizon Healthcare of New Jersey, Inc. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

Release of Information:

By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Horizon Healthcare of New Jersey, Inc. will release my information, including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Horizon Healthcare of New Jersey, Inc. or by Medicare.

Your Signature: _____ **Today's Date:** _____

If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

Phone Number: (____) _____ **Relationship to Enrollee:** _____

Medicare Advantage Plan Use Only:

Name of staff member/agency/broker (if assisted in enrollment): _____

Plan ID #: _____

Effective Date of Coverage: _____

ICEP/IEP: _____ OEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

The MA and MA-PD plans are managed care plans issued by Horizon Healthcare of New Jersey, Inc., which is an MA organization with a contract with the Centers for Medicare & Medicaid Services (CMS). Horizon Healthcare of New Jersey, Inc. is a subsidiary of Horizon Blue Cross Blue Shield of New Jersey. Both companies are independent licensees of the Blue Cross and Blue Shield Association.