



APPLICATION FOR ENROLLMENT OR CHANGE INSTRUCTIONS

To elect dental coverage, please fill out the attached form and return it to your Group Official.

APPLICANT INSTRUCTIONS

Complete the following information:

Box #1 - Dental Plan Option

- Check off Dental Plan - Check one plan only, either one of Horizon Blue Cross Blue Shield of New Jersey's indemnity dental plans OR one of Horizon Healthcare Dental, Inc.'s managed dental plans.

Box #4 - Coverage Requested

- Check off type of contract

Box #6 A. - Eligible Persons to be Enrolled

- Print last name, first name, middle initial, date of birth, sex, social security number for yourself and each dependent. *If dependent is over contract age, check off reason: student or handicapped.
- Continue for Horizon Dental Choice Enrollment Enter the HDC Identification number.

B. Marital Status of Applicant

- Check off appropriate box

Box #7 - Applicant's Address and Phone Number

- Print complete address and phone number

Box #8 A - E - Other Group Dental Insurance

- Print other group dental insurance information if you or any member of your immediate family have other dental insurance.

Box #9 - For Presently Enrolled Customers

Changing Their Coverage

- Enter date of event: Month/Day/Year
- Enter identification number

9A - Adding Dependent(s)

9B - Deleting Dependent(s)

9C - Continuing Coverage under COBRA

- Complete data where applicable

Box #10 - Signature

- Please sign and date the application, return it to your Group Official to complete Sections 2, 3 and 5.

*Horizon Dental Choice and Horizon TotalCare Plans ONLY

If you are requesting to change your Horizon Healthcare Dental Provider, you must complete Box #6 by selecting a new provider.

GROUP OFFICIAL INSTRUCTIONS

Complete the following information:

Box #2A - Group Name

- Print your company's name

2B - Group Number/Sub Group Number

- Enter 7-digit group number

*Horizon Dental Choice and Horizon TotalCare Plans Only

- Enter M with 7-digit group number

2C - Proposed Effective Date

- Enter applicant's proposed effective date of coverage

2D - Remitting Agent's Signature and Date

- Please sign and date the application

Box #3 - Reason for Application

- Check off the appropriate box

Box #5 - Employment Information

5A - Date of Hire

- Enter month/day/year

5B - Date of Rehire

- Enter month/day/year

5C - Is employee actively at work?

- Enter appropriate information

*Horizon Dental Choice and Horizon TotalCare Plans Only

If applicant is requesting to change their Horizon Healthcare Dental Provider, you must check off Box #3 indicating Change of Dentist

NOTE: To avoid processing delay, please review the entire application for completeness.



APPLICATION FOR ENROLLMENT OR CHANGE

Horizon Dental Programs
P.O. Box 1938
Newark, NJ 07101-1938
1-800-4DENTAL

1 DENTAL PLAN OPTION (Check one Box only)	2 GROUP INFORMATION (Section 1 to be completed by employer.)																																																																																								
Horizon Blue Cross Blue Shield of New Jersey <input type="checkbox"/> Horizon Dental Traditional Plan <input type="checkbox"/> Horizon Dental Option Plan <input type="checkbox"/> Horizon Dental PPO Plan <input type="checkbox"/> Horizon Dental PPO Access Plan	Horizon Healthcare Dental, Inc. <input type="checkbox"/> Horizon Dental Choice <input type="checkbox"/> Horizon TotalCare Dental																																																																																								
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">A. Group Name</td> <td style="width: 40%;">C. Proposed Effective Date</td> </tr> <tr> <td colspan="2">B. Group No. / Subgroup No.</td> </tr> <tr> <td colspan="2">D. Remitting Agent's Signature and Date</td> </tr> </table>		A. Group Name	C. Proposed Effective Date	B. Group No. / Subgroup No.		D. Remitting Agent's Signature and Date																																																																																			
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3 REASON FOR APPLICATION Please check the appropriate box(es). <input type="checkbox"/> New Hire <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Other _____ <input type="checkbox"/> Rehire <input type="checkbox"/> COBRA <input type="checkbox"/> Newly Eligible	4 COVERAGE REQUESTED Please check the appropriate box <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td rowspan="2">Type of Contract</td> <td>Single</td> <td>Husband and Wife</td> <td>Family</td> <td>Parent and Child(ren)</td> </tr> <tr> <td style="height: 20px;"></td> <td></td> <td></td> <td></td> </tr> </table>	Type of Contract	Single	Husband and Wife	Family	Parent and Child(ren)																																																																																			
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5 EMPLOYMENT INFORMATION A. Date of Hire: Mo. Day Yr. B. Date of Rehire: Mo. Day Yr. C. Is the employee actively at work? If yes, indicate the number of hours worked per week _____ <input type="checkbox"/> yes <input type="checkbox"/> no If no, check the appropriate box: <input type="checkbox"/> Pensioner <input type="checkbox"/> Disabled <input type="checkbox"/> Other (specify) _____																																																																																									
6 ELIGIBLE PERSONS TO BE ENROLLED A. Complete this box for yourself and all dependents enrolling. Attach another application if you have more than four children. (Note: Dependent children are covered under a parent's contract only until they reach contract termination age as specified in the group contract.) <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>LAST NAME</th> <th>FIRST</th> <th>MI</th> <th colspan="3">DATE OF BIRTH</th> <th>SEX</th> <th>FULL TIME STUDENT OVER CONTRACT AGE</th> <th>HANDICAP OVER CONTRACT AGE</th> <th>SOCIAL SECURITY NUMBER</th> <th>Horizon Dental Choice/ Horizon TotalCare Dental Plans or HTCD DENTIST ID #</th> </tr> <tr> <th></th> <th></th> <th></th> <th>MO</th> <th>DAY</th> <th>YR</th> <th>M/F</th> <th></th> <th></th> <th></th> <th></th> </tr> </thead> <tbody> <tr> <td>Applicant</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Spouse</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Child</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>*</td> <td>*</td> <td></td> <td></td> </tr> <tr> <td>Child</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>*</td> <td>*</td> <td></td> <td></td> </tr> <tr> <td>Child</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>*</td> <td>*</td> <td></td> <td></td> </tr> <tr> <td>Legal Ward</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <p>* Verification is required for dependents over contract age for full time students and/or handicap.</p>		LAST NAME	FIRST	MI	DATE OF BIRTH			SEX	FULL TIME STUDENT OVER CONTRACT AGE	HANDICAP OVER CONTRACT AGE	SOCIAL SECURITY NUMBER	Horizon Dental Choice/ Horizon TotalCare Dental Plans or HTCD DENTIST ID #				MO	DAY	YR	M/F					Applicant											Spouse											Child							*	*			Child							*	*			Child							*	*			Legal Ward										
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B. MARITAL STATUS OF APPLICANT <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(er)																																																																																									
7 APPLICANT'S ADDRESS AND PHONE NUMBER Street _____ Area Code _____ City _____ State _____ Zip Code _____																																																																																									
8 OTHER GROUP DENTAL INSURANCE (Please complete this if you or any member of your immediate family has other dental insurance.) A. Name of Policy Holder (Last, First) _____ B. Policy or Identification Number _____ C. Name of other Insurance Company _____ D. Address of other Insurance Company _____ E. Name and Location (City, State) of Spouse's Employer _____																																																																																									
9 FOR PRESENTLY ENROLLED CUSTOMERS CHANGING THEIR COVERAGE (Check reason(s) for change and indicate the date of the event and ID number.) <table style="width: 100%;"> <tr> <td style="width: 40%;">DATE OF EVENT</td> <td style="width: 10%;">MO</td> <td style="width: 10%;">DAY</td> <td style="width: 10%;">YR</td> <td style="width: 30%;">IDENTIFICATION NO.</td> </tr> <tr> <td style="border: 1px solid black; height: 20px;"></td> <td style="border: 1px solid black; width: 20px;"></td> <td style="border: 1px solid black; width: 20px;"></td> <td style="border: 1px solid black; width: 20px;"></td> <td style="border: 1px solid black; width: 50%;"></td> </tr> </table> COPY FROM YOUR ID CARD		DATE OF EVENT	MO	DAY	YR	IDENTIFICATION NO.																																																																																			
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A. ADDING DEPENDENT(S) (Be sure to complete section 6A.) <input type="checkbox"/> Marriage <input type="checkbox"/> Legal Ward <input type="checkbox"/> Spouse's Coverage Terminated <input type="checkbox"/> Child <input type="checkbox"/> Adoption <input type="checkbox"/> Previously Refused/Waived Coverage <input type="checkbox"/> Other (specify) _____																																																																																									
B. DELETING DEPENDENT(S) <input type="checkbox"/> Divorced/Separation <input type="checkbox"/> Coverage Elsewhere <input type="checkbox"/> Child Reached Termination Age or Married <input type="checkbox"/> Death <input type="checkbox"/> Entered Military <input type="checkbox"/> Other (specify) _____ Names of Dependents Being Deleted: _____ <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)																																																																																									
C. CONTINUING COVERAGE UNDER COBRA <input type="checkbox"/> Spouse of Deceased Employee <input type="checkbox"/> Reduction in hours/no longer meets Group's eligibility requirements <input type="checkbox"/> Employment Terminated <input type="checkbox"/> Dependent Child no longer eligible under terms of employer's health plan <input type="checkbox"/> Divorced <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Disabled																																																																																									
10 SIGNATURE I hereby apply to the company identified in Section One ("Horizon"), on behalf of myself and any eligible dependents listed. I understand and agree that any coverage provided pursuant to this application will be at the level of benefits available through arrangements between Horizon and my group. I hereby accept responsibility for payment of any portion of the premium, if applicable, which I have agreed to pay through the group. I further acknowledge that coverage shall become effective only if approved by Horizon and such services which are rendered on or after the affective date of coverage. I authorize Horizon to request information from providers to assist in claims processing and to accept claims submitted electronically by third parties. I certify to the best of my knowledge and belief the information on this application is complete and true. I understand that any claim by me or one of my eligible dependents may be denied and my coverage cancelled without prior written notice if I have included false information. I also understand that such a termination will be retroactive to the effective date of our coverage. Signature of Applicant _____ Date _____ Horizon Healthcare Dental, Inc. is a wholly-owned subsidiary of Horizon Blue Cross Blue Shield of New Jersey. Horizon Blue Cross Blue Shield of New Jersey and Horizon Healthcare Dental, Inc. are independent licensees of the Blue Cross and Blue Shield Association.	FOR PLAN USE ONLY INPUT DATE AND INITIAL _____ VERIFY DATE AND INITIAL _____																																																																																								