Reset Form

Horizon
Horizon Blue Cross Blue Shield of New Jersey

ENROLLMENT/CHANGE REQUEST

Horizon BCBSNJ Dental Programs

P.O. Box 1710
Newark, NJ 07101-1938
www.HorizonBlue.com/dental
1-800-4DENTAL

Group Information - To Be Completed by Employer

Group Name	Group Number	Subgroup Number
Yale School	96299	00

A. Type of Activity - To Be Completed by Employer

Refer to instructions on back before completing this form. Print clearly.

1. Enrollment

☐ New Subscriber

Effective Date

_____/_____/_____

Date of Hire

_____/_____/_____

2. Change - *Check all that apply.*

	Date of Event	Reason
☐ Add Spouse	___/___/___	_____
☐ Domestic Partner		
☐ Civil Union Partner	___/___/___	_____
☐ Add Dependent Child	___/___/___	_____
☐ Name Change	___/___/___	_____
☐ Change Plan	___/___/___	_____
☐ Other	___/___/___	_____
☐ Add/Change Dentist Office ID		

3. Remove or Terminate - *Check all that apply.*

	Effective Date	Reason
☐ Remove Spouse/Domestic Partner/ Civil Union Partner*	____/____/____	_____
☐ Remove Dependent Child*	____/____/____	_____
☐ 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: ☐ Employee ☐ Dependents
Length of Continuation: ☐ 18 mos ☐ 29 mos* ☐ 36 mos ☐ 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 BCBSNJ	Horizon Healthcare Dental	Contract Type
☐ Horizon Dental Traditional	☐ *Horizon Dental Choice	☐ S - Single ☐ F - Family
☐ Horizon Dental Option	☐ *Horizon TotalCare Dental	☐ 2 Adults
☐ Horizon Dental PPO		☐ P/C - Parent & Child
☑ Horizon Dental PPO Access		

*Please select Dentist Office ID Number-Section D

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. Attach proof if full-time college student. Attach proof of disability.

	(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex M F	Birthdate MM DD YYYY	Social Security Number	Other Dental Coverage Check if Yes	Dentist Office ID Number (if applicable)	NPI Number	Current Patient Check if Yes	Previous Coverage Check if Yes
Employee			☐ ☐	/ /		☐			☐	☐
Spouse			☐ ☐	/ /		☐			☐	☐
Domestic Partner			☐ ☐	/ /		☐			☐	☐
Civil Union Partner			☐ ☐	/ /		☐			☐	☐
Child			☐ ☐	/ /		☐			☐	☐
Child			☐ ☐	/ /		☐			☐	☐
Child			☐ ☐	/ /		☐			☐	☐

E. Other/Previous Insurance

Is your Spouse/Domestic Partner/Civil Union Partner Employed? ☐ Yes ☐ No If "Yes," give name & address of spouse's/ Domestic Partner's/Civil Union Partner's employer.

If "Yes" to Other Dental Coverage (Section D), give name & policy number of insurance carrier, HMO, or other source.

If "Yes" to previous coverage, identify name(s) of persons, give effective date and date coverage terminated, name of previous carrier and plan number and submit a copy of the Certificate of Credible Coverage issued by the previous carrier, if available.

F. Dependent Information

Does any dependent listed in Section D live at a different address than the Employee? ☐ Yes ☐ No If "Yes," who and at what address?

Explain the circumstances.

If any dependent's last name differs from yours, explain the circumstances.

G. Employee Signature

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.

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

Date / /

E-Mail Address

H. Employer Verification - To Be Completed by Employer

Employer Signature - *Required*

X

Title

Date / /

Employee copy may be used as a temporary ID card for 30 days from the effective date if authorized by employer. Coverage must be verified with Horizon BCBSNJ Dental Programs prior to visiting a specialist or admission to a hospital.

You may complete the required fields below online and then save or print a copy for submission. To save a completed copy to your computer, choose File > Save As to rename the file and save the form with your information to your computer.