Horizon

Horizon Blue Cross Blue Shield of New Jersey

Please return application to Group, Union, and/or Broker when completed.

EMPLOYER/UNION GROUP HEALTH PLAN ENROLLMENT REQUEST FORM

To enroll into a Horizon Medicare Advantage Group plan, please provide the following information:

Employer or Union Name: _____

Medicare Advantage Group # (if known): _____

Please Provide Information About You *(Please print clearly)*

Requested effective date of coverage:

☐☐ / ☐☐ / ☐☐☐☐

Birth Date: ☐☐ / ☐☐ / ☐☐☐☐

Sex: ☐ M ☐ F

Home Phone Number: (☐☐☐) ☐☐☐ - ☐☐☐☐

☐ Mr. ☐ Mrs. ☐ Ms.

LAST Name: ☐☐☐☐☐☐☐☐☐☐ FIRST Name: ☐☐☐☐☐☐ Middle Initial: ☐

Permanent Residence Street Address: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

(PO Boxes are not allowed. Applications submitted with a PO Box will not be processed.)

City: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ State: ☐☐ ZIP Code: ☐☐☐☐☐

Mailing Address (only if different from your Permanent Residence Address):

Street Address: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

City: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ State: ☐☐ ZIP Code: ☐☐☐☐☐

Email Address*:(optional) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

- OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Medicare Claim Number

☐☐☐☐ - ☐☐☐ - ☐☐☐☐

Is Entitled To	Effective Date
HOSPITAL (Part A)	☐☐ - ☐☐ - ☐☐
MEDICAL (Part B)	☐☐ - ☐☐ - ☐☐

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

Please Read and Answer These Important Questions

1. Are you the retiree?

☐ Yes ☐ No

If yes, retirement date (month/date/year):

_____

If no, name of retiree:

_____

2. Do you or your spouse work?

☐ Yes ☐ No

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

☐ Yes ☐ No

If you have had a successful kidney transplant and/ or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis; otherwise, we may need to contact you to obtain additional information.

4. Some individuals may have other drug coverage, including other private insurance, Workers' Compensation, VA benefits or State pharmaceutical assistance programs.

Will you have any other prescription drug coverage in addition to the Horizon Medicare Advantage Group coverage?

☐ 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:

_____

5. 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):

_____

_____

_____

_____

Please choose a Primary Care Physician (PCP) and Location code (HMO-POS members who do not select a PCP, specialist copay will apply):

Name: _____

Location Code: _____

Please contact Horizon Blue Cross Blue Shield of New Jersey at **1-888-425-9435** (TTY/TDD users should call **711**) if you need additional information. Our office hours are Monday through Friday, 8 a.m. to 5 pm., Eastern Time.

Please Read and Sign Below

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

Horizon Medicare Blue Group Plans are Medicare Advantage plans and have a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can only be in 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. 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 don't 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. Horizon Medicare Blue Access Group (HMO-POS) serves a specific service area. If I am enrolling in a Horizon Medicare Blue Access Group (HMO-POS) plan and I move out of the area that this plan serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand this last statement does not apply to the Horizon Blue Group (PPO) plan. Once I am a member of Horizon Medicare Blue Group Plans, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Member Evidence of Coverage document from Horizon Medicare Blue Group Plans when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually 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 Medicare Blue Group Plans coverage begins, I must get all of my health care from Horizon Medicare Blue Group Plans, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Horizon Medicare Blue Group Plans and other services contained in my Horizon Medicare Blue Group Plans Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE OR HORIZON MEDICARE BLUE GROUP PLANS WILL PAY FOR THE SERVICES.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Horizon Medicare Blue Group Plans, he/she may be paid based on my enrollment in Horizon Medicare Blue Group Plans.

MAPD Plans Only – if you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay Horizon Blue Cross Blue Shield of New Jersey the Part D-IRMAA.

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 Medicare.

Signature: X _____ Today's Date: _____

If you want to identify a personal representative, you must complete a "Request for Personal Representative" form which will allow you to identify another person who can speak on your behalf.

Office Use Only

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

_____

Plan ID #: _____

Effective Date of Coverage: _____

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

Horizon Insurance Company, Inc. ("HIC") has contracts with CMS for HMO, PPO and Part D Medicare plans. Enrollment in HIC Medicare products depends on contract renewal. Products are provided by HIC, however, communications are issued by Horizon Blue Cross Blue Shield of New Jersey in its capacity as administrator of programs and provider relations for all its companies. Both companies are independent licensees of the Blue Cross and Blue Shield Association.