Horizon Blue Cross Blue Shield of New Jersey

Horizon Medicare Advantage and Part D Employer Application

Please fill in the information below and return the completed form to Horizon Blue Cross Blue Shield of New Jersey via one of these two easy ways (originals not required):

1. **Fax:** 973-274-4075 OR
2. **Email:** MAPDGroups@horizonblue.com

Please make sure all fields on this application are complete and legible to ensure timely processing. Any incomplete applications will not be processed and will be returned.

Company/Business Legal Name: ______

Company Headquarters Address: ______

City: ______ State: ______ ZIP: ______

County: ______ Phone: ______

Fax Number: ______ Type of Industry: ______

Standard Industrial Classification (SIC) Code: ______ Tax ID: ______

Please Indicate Your Employer Group Sponsor Type: **MUST select one:**

- ☐ Employer (1)
- ☐ Union (2)
- ☐ Trustees of a Fund (3)

Please Indicate Your Employer Group Organization Type: **MUST select one:**

- ☐ State Government (1)
- ☐ Local Government (2)
- ☐ Publicly Traded Corp. (3)
- ☐ Privately Held Group (4)
- ☐ Non-Profit (5)
- ☐ Church Group (6)
- ☐ Other (7) ______

Please Indicate Contract Type: **MUST select one:**

- ☐ Insured (1)
- ☐ ASO (2)
- ☐ Other (3) ______

Company Official/Owner:

Name: ______

Title: ______

Address: ______

City: ______ State: ______ ZIP: ______

County: ______

Phone: ______

Email: ______

Broker/Producer:

Name: ______

Address: ______

City: ______ State: ______ ZIP: ______

County: ______

Phone: ______

Email: ______

Broker Number: ______

Company Remitting/Billing Agent:

Name: ______

Title: ______

Address: ______

City: ______ State: ______ ZIP: ______

County: ______

Phone: ______

Email: ______

General Agency or Master Broker Producer is associated with:

Name: ______

Address: ______

City: ______ State: ______ ZIP: ______

County: ______

Phone: ______

Email: ______

Broker Number: ______

Current Horizon Group # (if applicable): ____

For all PDP and MA/MAPD Groups larger than 20: Are all enrollees fully retired? ☐ YES ☐ NO

Requested Effective Date (Note: May take up to 3 weeks to implement): _____ /_____ /_____

Please indicate a Horizon Medicare Advantage (MA) and/or Part D Prescription (PDP) group plan option number and rate:

☐ MA (HMO-POS) ☐ MAPD (HMO-POS) ☐ MA (PPO) ☐ MAPD (PPO) ☐ Part D only (PDP)

Health Plan Option Number: ____ Rate: ____________

Rx (PDP) Plan Option Number: ____ Rate: ____________

Total Monthly Premium Amount/pmpm: $ ____

Overall Group Size (# of employees in group): ____

MA Group Size (total # of Medicare-eligible members enrolling on original effective date only): ____________________

Employer – Please confirm that all enrollees have obtained creditable prescription drug coverage when they were first eligible for coverage and have not had a break in creditable prescription drug coverage of at least 63 consecutive days.

☐ Confirmed

Employer Signature: ____ Date: ____________

Employer Print Name: ____ Rate: ____________

Broker Signature: ____

Broker Print Name: ____