# 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.**

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**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) _____

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**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: _____

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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):_____

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Please confirm if there will be any enrollees with ESRD? ☐ YES ☐ NO

If so, how many?_____

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: _____

DO NOT SEND PAYMENT