Horizon Blue Cross Blue Shield of New Jersey

Small Employer Health Plus Plan

NEW CASE SUBMISSION MATERIALS CHECKLIST

1) Submit Bundled Benefit and Rate Sheet (pdf generated by HealthConnect) **OR** applicable plan benefits sheet within marketing brochure.

2) Complete the following applications:

   a. Application for Dental and Vision Benefits Through Small Employer Health Plus- form 32337
      i. Low package option- Horizon Family Grins and Horizon Vista II
      ii. High package option– Horizon Family Grins Plus and Horizon Panorama IV (Alt B)

   b. USAble* Application-form SG2-APP-NJ(5-09)
      i. Complete highlighted sections only.
      ii. Groups with the following SIC codes are ineligible: 14xx, 2892-2899, 3292, 45xx, 7381, 88xx, 9999
      iii. Beneficiary forms are retained by the group.

   Important notes:
   - Please note that when the group is already enrolled in a Horizon Small Employer health plan, no deposit premium is required.
   - For employees who waived health coverage and would like to enroll in Small Employer Health Plus, submit completed Enrollment/Change Request forms.

3) Submit applications to your Horizon Master Broker.

*USAble Life is an independent company that operates separately from Horizon BCBSNJ. USAble Life does not sell or service Horizon BCBSNJ products and is solely responsible for the life, disability and accident products referenced herein. Life insurance policy is issued and billed directly by USAble. Please call (800) 370-5856 for questions regarding the Life and AD&D portion of the program.

Horizon

Horizon Blue Cross Blue Shield of New Jersey

RESET

APPLICATION FOR DENTAL AND VISION BENEFITS THROUGH A SMALL EMPLOYER HEALTH PLUS PLAN

Vision benefits are provided by Horizon Insurance Company and Dental Benefits are provided by Horizon Health Services.

Please print or type ___ New Policy ___ Change in Policy Policy No. _____ Requested Effective Date _____

SECTION I: POLICYHOLDER INFORMATION

1. Policyholder (full legal name of company): _____

2. Tax Identification Number: _____

3. Main Address: _____
Street City State ZIP

Mailing Address (Billing): _____
Street City State ZIP

Telephone: ____- ____-_____ Facsimile: ____-____-_____ Email Address _____

4. Name of Company Official: _____ Title: _____

5. Type of Organization: ___ Corporation ___ Partnership ___ Proprietorship ___ Other (explain): _____

6. Nature of Business (specify): _____ SIC Code: _____

7. Number of full-time employees in your company: _____ 8. Number of full-time employees to be insured: _____
(Full-time employees are those who work at least 25 hrs. per week)

9. Class or classes to be excluded: _____

10. Insurance Requested For:
☐ Employees Only ☐ Employees and Dependents including Spouse ☐ Employees and Dependents excluding Spouse

11. Is the employer subject to the requirements of COBRA? ___ Yes ___ No

12. Waiting period before employees become insured:
Present employees: ___ No waiting period ____ One month ____ Two months ____ 90 days
New or rehired employees: ____ No waiting period ____ One month ____ Two months ____ 90 days

13. Deposit $ (if applicable) _____
Premium Paid: ____ Monthly ____ Automatic checking withdrawal

SECTION II: SPECIFICATIONS FOR COVERAGE

Select one of the following:

☐ **Low package option**
Horizon Family Grins
Horizon Vista II

☐ **High package option**
Horizon Family Grins Plus
Horizon Panorama IV

SECTION III: SIGNATURE

It is understood that no individual shall become insured while not actively at work on a full-time basis, and only full-time employees are eligible. A full-time employee is one who regularly works at least 25 hours per week at his employer's place of business. It is further understood that no agent has power on behalf of Horizon Blue Cross Blue Shield of New Jersey to make or modify any request or application for insurance or to bind Horizon Healthcare Dental, Inc. and/or Horizon Healthcare Services, Inc. on behalf of Horizon Blue Cross Blue Shield of New Jersey, Inc. by making any promise or representation or by giving or receiving any information.

It is further understood that no insurance will be effective unless and until the application is accepted in writing by Horizon Blue Cross Blue Shield of New Jersey, Inc. No contract of insurance is to be implied in any way on the basis of the completion and or submission of this application. Any person who knowingly files a statement of claim, application for insurance, enrollment form, or certification containing any false or misleading information may be subject to criminal and civil penalties.

_____ _____

Print name of Officer, Partner, or Owner Signature of Officer, Partner, or Owner

_____ Dated at _____ on _____

Witness to Signature

Note: If there are any modifications to the statements and answers given in this application (i.e., crossed out, whited-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.

AGENT/PRODUCER INFORMATION (THIS INFORMATION MUST BE ANSWERED COMPLETELY)			
BROKER SIGNATURE	DATE		VENDOR NUMBER
BROKER-NAME	NAME OF AGENCY		TELEPHONE NUMBER
STREET	CITY	STATE	ZIP CODE
OTHERS (NAME, TITLE)			
SPECIAL INSTRUCTIONS			

FOR INTERNAL GROUP DENTAL AND VISION ENROLLMENT USE	
Coverage Code	
TOTAL APPLICATIONS SUBMITTED	
TRANSFER FROM GROUP #_____	
EMPLOYER CONTRIBUTION	
EFFECTIVE DATE	
FUTURE RATE RENEWAL DATE	

	SALES ASSOCIATE SIGNATURE	DATE	ITEM NUMBER
APPROVED BY:	SALES ADMINISTRATION SIGNATURE	TITLE	DATE

USAble Life

P.O. Box 1650
Little Rock, Arkansas 72203

SMALL GROUP INSURANCE APPLICATION (GIIM)

Type or Print in Black Ink

SECTION I. GROUP INFORMATION:

1. Legal Name of Policyholder:	2. Taxpayer ID#:	3. Effective Date of Coverage:

4. Type of Company: ❑ Corporation ❑ LLC ❑ PC ❑ S-Corp ❑ Sole Proprietor ❑ Partnership ❑ Government ❑ Other _____

5. Nature of Business	6. SIC Code	7. Name of Subsidiary or Affiliate Companies to be Covered	8. SIC Code/Affiliate

9. Mailing Address of Policyholder City State Zip+4

10. Contact Information at Company:

❑ Benefits or ❑ Billing Contact Person _____

Phone/Fax Number _____ E-mail Address _____ Web Address _____

11. Class Definitions. Small Group is limited to three classes with a minimum of 2 employees/class. *Voluntary plans are limited to one class.*

Class	Life	LTD	Grp.	Vol.	Description of Class	Waiting Period, if Different
1	☒	❑	❑	❑	All active full time employees enrolled in the Small Employer Heath Plus plan	
	❑	❑	❑	❑		
	❑	❑	❑	❑		

12. Do you have any employees located in states other than the Policyholder's main address? (if yes, please indicate states below)
❑ Yes ❑ No _____

13. Billing Method: ❑ Credit Card/Bank draft
❑ Billed by Blue Plan ❑ Self Administered
❑ On-Line Billing ☒ List Bill

14. Total number of eligible employees:	15. Total number of employees enrolled:	16. Employer contribution:
Group: _____ Voluntary: N/A_____	Group: _____ Voluntary: _N/A_____	Group: 100.00 Voluntary: _N/A_____

17. Waiting Period: ❑ First of the following month after completion of _____ days, or
❑ Day following Hire Date (*VLTD requires a 30 day minimum waiting period.)*

18. Minimum hours per week:
Group: 25 Voluntary:N/A_____

19. Eligible Waiting Period Applies to: ❑ Future Employees Only ❑ Present & Future Employees
Does the waiting period apply to employees rehired within 12 months of their termination date ❑ Yes ❑ No

19a. Annual Enrollment date for Voluntary Coverage: __N/A_____

20. Replacement: Are any of the following a replacement of similar coverage? *If prior coverage, please include a copy of the prior carrier's plan.*

Yes	No	Grp.	Vol.	Coverage	If Yes, Previous Carrier	Termination Date
❑	☒	❑	❑	Life & AD&D Insurance		
❑	❑	❑	❑	Long Term Disability	N/A	

SECTION II. EMPLOYER BENEFIT OPTIONS: *FOR GROUPS WITH 2 TO 50 ELIGIBLE EMPLOYEES*

SELECT COVERAGES THAT BEST MEET THE GROUP'S NEEDS. Term Life/AD&D is required for LTD purchase.

STEP 1: Select the Life/AD&D and LTD Coverage for the Employees and the Class Applicable for that Amount

Group Term Life and AD&D Insurance

Choice	Class (Circle one)	No. of ee's	Term Life and AD&D Benefit
☒	1, 2, 3	_____	$25,000
❑	1, 2, 3	_____	$35,000
❑	1, 2, 3	_____	$40,000*
❑	1, 2, 3	_____	$50,000*

Group Long Term Disability

Choice	Class (Circle one)	No. of ee's	LTD Benefit	Duration	
				5 YR RBD	65 RBD
❑	1, 2, 3	_____	$500	❑	❑
❑	1, 2, 3	_____	$750	❑	❑
❑	1, 2, 3	_____	$1,000	❑	❑
❑	1, 2, 3	_____	$1,500*	❑	❑
❑	1, 2, 3	_____	$2,000*	❑	❑

**Requires a minimum of 5 eligible employees participating. Amounts between classes may not exceed 2x the lower amount.*

STEP 2: Select Enhancements to the Group Coverages			
☒	Dependent Life Coverage: Spouse**/child: $5,000/$2,000 (*Child coverage from 14 days to 6 months is limited to $100)*	❑	Double the amount of the AD&D benefit.

SECTION III. EMPLOYEE BENEFIT OPTIONS (VOLUNTARY PLANS): *FOR GROUPS WITH 10 TO 50 ELIGIBLE EMPLOYEES*

Instructions: Group must elect Group Term Life/AD&D if VGTL/VAD&D or VLTD is desired. The employer cannot offer both group LTD and voluntary LTD.

❑ **Voluntary* Term Life & AD&D**	**Benefits**	
Employee (Life & AD&D)	*Available amounts from $20,000 to $50,000 in $10,000 increments*	
Dependent (Life only – spouse**/child)	*Available amounts of $10,000/$5,000 or $20,000/$10,000*	
❑ **Voluntary* LTD**	❑ 5 yr RBD or ❑ To Age 65 RBD	*The employer elects duration and one monthly benefit amount for all employees. The employee elects to purchase.*
Available Monthly Benefit Amounts	❑ $500; ❑ $750; ❑ $1,000; ❑ $1,500	

**All voluntary plans require a minimum of 10 eligible employees, with a minimum of 5 participating or 25%, whichever is greater*

TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT FEATURES:

Group and Voluntary AD&D Riders		Benefits reduce by the following amounts on the insured's birthday*			
Group & Voluntary Plans	*Voluntary Plans*	Reduction at Age of Employee			
☒ Seat Belt /Air Bag	☒ Special Education	Age 65		Age 70	
☒ Coma	☒ Spouse** Training	☒	35%	☒	50%
☒ Repatriation		* Benefits for the covered person(s) terminate when no longer eligible or at retirement, whichever comes first.			
☒ Exposure and Disappearance					

LONG TERM DISABILITY FEATURES:

Disability Definition: Earnings / Occupation Test (80/20);24 month own occupation	Drug & Mental Illness Limitation: 24 Month Lifetime Benefits
Elimination Period: 180 Days (Group & Voluntary)	Benefit Percentage: Flat benefit not to exceed 60% of pre-disability earnings
Pre-existing Condition:Group LTD: 3/12; Voluntary LTD: 12/6/24	Integration: non-integrated; Voluntary amounts above $1,000 are integrated.

W-2 Service Options for Long Term Disability

❑ Option 1: Withhold Federal income Taxes and the employee's portion of FICA. Prepare and File W-2 Forms.

❑ Option 2: Withhold Federal income Taxes and the employee's portion of FICA. Policyholder waives W-2 Forms Services.

A detailed description of the W-2 services elected by the Policyholder pursuant to this application will be sent to the Policyholder by mail. Such services will be performed in accordance with the above election and established standard procedures.

*** Spouse means a spouse or civil union partner. A civil union is defined as a relationship that meets the requirements pursuant to New Jersey's Civil Union Act and includes same-sex relationships from other jurisdictions that provide substantially all of the rights and benefits of marriage.*

SECTION IV. AUTHORIZATION:

REMARKS OR SPECIAL PROVISIONS:

The undersigned employer and /or authorized representative hereby: (a) request that it be approved for insurance coverage through USAble Life and agree to comply with all terms and provisions of the Group Policy (ies) issued in response to this application; (b) certify that the statements and answers given in this application are true, complete and correctly recorded to the best of their knowledge and belief

It is understood and agreed that this application shall be made a part of the policy or policies applied for and that no insurance shall be effective until approved by USAble Life.

Warning: Any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

_____	_____	_____
Dated at (City & State)	Date	Signature of Policyholder and Title
_____	_____	
Name of Licensed Agent	Signature of Licensed Agent	

For Home Office Use Only
Group #