Reset Form

Horizon®

GROUP INFORMATION:

Group Number _____ Effective Date _____

Group's legal name _____

Primary location address: Street _____

City _____ State _____ Zip code _____ Telephone number _____

Billing address: _____ City _____ State _____ Zip code _____

Tax ID number _____ SIC code (4-digit) _____ Type of industry _____

Group official: Name _____ Title _____

Telephone number _____ Email _____

Group administrator: Name _____ Title _____

Telephone number _____ Email _____

Union affiliation: ☐ No ☐ Yes If yes, list name/number of Local _____

Current carrier(s) replaced _____

GROUP ENROLLMENT INFORMATION:

Number of employees: Eligible _____ Enrolling on the plan _____

ID cards mailed to (choose one): ☐ Group ☐ Employee's home (Note: Vision ID cards are mailed to employee's home)

Contract mailed to (choose one): ☐ Group ☐ Broker

Method of billing: ☐ Traditional ☐ ASC ☐ Minimum premium

Open enrollment: ☐ Annually ☐ Semi-Annually ☐ Other (explain) _____

Medical/Prescription

Funding: ☐ Fully insured ☐ Self-insured ☐ Level funded

Employer contribution: Single _____ Two Adults _____ Family _____ Parent/Child(ren) _____

Dental: ☐ Contributory ☐ Voluntary

Funding: ☐ Fully insured ☐ Self-insured

Employer contribution: Single _____ Two Adults _____ Family _____ Parent/Child(ren) _____

Vision: ☐ Contributory ☐ Voluntary

Funding: ☐ Fully insured ☐ Self-insured

Employer contribution: Single _____ Two Adults _____ Family _____ Parent/Child(ren) _____

PRODUCT INFORMATION: (check all that apply)

☐ Medical - Include signed Proposal Rate Page showing Medical Product selected

☐ Prescription - Include signed Proposal Rate Page showing Prescription Product selected

☐ Dental - Include signed Proposal Rate Page showing Dental Product selected

☐ Vision - Include signed Proposal Rate Page showing Vision Product selected

GROUP ELIGIBILITY INFORMATION:

Waiting period (may not exceed 90 days for Medical/Rx)

New hires (choose one):

- ☐ Date of employment (no waiting period)
- ☐ 1st of the month following date of employment
- ☐ 1st of the month following one month of employment
- ☐ 1st of the month following 30 days of employment
- ☐ 1st of the month following 60 days of employment
- ☐ 1 month from date of employment
- ☐ 2 months from date of employment
- ☐ 30 days from date of employment
- ☐ 60 days from date of employment
- ☐ 90 days from date of employment
- ☐ Upon retirement
- ☐ Other (100+ Enrolled and Public Sector groups only) _____

Rehires (choose one):

- ☐ Date of rehire (no waiting period)
- ☐ Same as new hire
- ☐ Other (100+ Enrolled and Public Sector groups only) _____

Class of employees eligible for benefits (check all that apply and list number hours):

- ☐ Full-Time List the number of Full-Time hours _____
- ☐ Part-Time List the number of Part-Time hours _____

Retired employees (check all that apply and list number of years):

- ☐ Not covered
- ☐ Medical/Rx List the minimum number of years _____
- ☐ Dental List the minimum number of years _____
- ☐ Vision List the minimum number of years _____

Domestic Partners (check all that apply):

- ☐ Not covered
- ☐ Same-sex domestic partner coverage
- ☐ Opposite-sex domestic partner coverage

Termination of employee (choose one):

- ☐ Date of event
- ☐ End of the month

Massachusetts Resident (fully insured groups only, choose one):

Do you have any employees residing in the state of Massachusetts? ☐ Yes ☐ No

ERISA INFORMATION:

Is group subject to ERISA? ☐ No ☐ Yes If yes, provide additional information below:

ERISA plan year _____ ERISA plan number (3-digit) _____ ERISA plan code number _____

ERISA plan administrator: Name _____ Title _____

ERISA plan sponsor: Name _____ Title _____

MEDICARE INFORMATION:

Is the employer subject to the requirements of Medicare Secondary Payer (MSP) rules due to disability?

(In general, the group health plan covers employees of either an employer or employee organization that has at least 100 employees - For further details, refer to the ADDENDUM) ☐ Yes ☐ No

BROKER INFORMATION:

Broker/Producer (if applicable):

Company name _____ Vendor number _____

Address _____ City _____ State _____ Zip code _____

Contact name _____ Telephone number _____

Email _____

Broker Signature _____ Date _____

Master Broker/GA (if applicable):

Company name _____ Vendor number _____

Address _____ City _____ State _____ Zip code _____

Contact name _____ Telephone number _____

Email _____

Broker Signature _____ Date _____

COMMISSION INFORMATION:

Medical/Rx commission of _____ % Dental commission of _____ % Vision commission of _____ %

I authorize the aforementioned Commissioned Broker to be the Broker of Record for our health insurance. This contract will be valid until Horizon BCBSNJ is notified in writing to cancel. Commissions should be paid to our group's Broker of Record beginning on our effective/anniversary date. Further, we agree that any such notice shall apply prospectively to future contract renewals.

Any person who includes any false or misleading information on an application or enrollment form for a health benefits plan is subject to criminal and civil penalties.

Group official: Name _____

Group official's signature _____ Date _____

ADDENDUM:

In the MEDICARE INFORMATION section, respond Yes to the question when the employer meets the following definition Large Group Health Plan that applies to Medicare Secondary Payer (MSP) Rules due to disability.

Large Group Health Plan means a group health plan that covers employees of either:

- A single employer or employee organization that employed at least 100 full-time or part-time employees on 50 percent or more of its regular business days during the previous calendar year;
- Two or more employers or employee organizations at least one of which employed at least 100 full-time or part-time employees on 50 percent or more of its regular business days during the previous calendar year.

Employers are encouraged to consult with their own legal counsel to determine their precise size for MSP purposes.