

# OTHER ITEMS REQUIRED WITH SUBMISSION OF POLICY

## WR30

ATTACH A COPY OF YOUR WR30 (WAGE & PAYROLL) FOR THE LASTEST QUARTER OR APPROPRIATE TAX DOCUMENTATION

- ✓ *OXFORD REQUIRES NO WR30*
- ✓ *AETNA REQUIRES WR30 FOR LESS THAN 5 ENROLLING, BUT IT IS A 6 EE ELIGIBLE GROUP*
- ✓ *ALL OTHER CARRIERS REQUIRE WR30 2-5 ELIGIBLE. IN OTHER WORDS IF THE GROUP HAS 6 ELIGIBLE EMPLOYEES, BUT ONLY 3 ENROLLING, WR30 IS NOT NECESSARY UNLESS UNDERWRITING COMES BACK AND MAKES A REQUEST TO SEE IT.*

## CARRIER BILL

A COPY OF YOUR LAST BILLING STATEMENT SHOWING ALL THE EMPLOYEES ENROLLED FROM YOUR PREVIOUS CARRIER

## PREMIUM CHECK

ALL NEW CASES MUST SUBMIT A CHECK MADE OUT TO THE CARRIER WITH THE ESTIMATED MONTHLY PREMIUM AMOUNT FROM THE QUOTE. THIS MUST BE A COMPANY BUSINESS CHECK

## QUOTE

ATTACH A COPY OF THE QUOTED ESTIMATED PREMIUM. PLEASE CIRCLE THIS PLAN DESIGN AND AMOUNT AND HAVE THE CLIENT SIGN THEIR NAME ANYWHERE WITHIN THE PLAN DESCRIPTION OR BY THE RATES. THIS IS AN ACKNOWLEDGEMENT OF PLAN DESIGN/RATES QUOTED.

## TERMINATION OF PRIOR CARRIER

DON'T FORGET TO SEND A LETTER OFF TO THE PRIOR CARRIER, CANCELLING THE COVERAGE. PLEASE DO NOT DO SO UNTIL YOU RECEIVE APPROVAL ON THE COVERAGE THAT YOU ARE APPLYING FOR. PLEASE NOTE THAT ALL CARRIERS REQUIRE YOU TO CANCEL PRIOR OR 30 DAYS BEFORE YOUR EFFECTIVE DATE OF YOUR RENEWAL. OTHERWISE, THEY HAVE THE RIGHT TO BILL YOU. SO, YOU MAY WANT TO PUSH OUT YOUR NEW COVERAGE EFFECTIVE DATE. PLEASE CONSULT YOUR BROKER TO CHECK ON TIMEFRAMES.



Horizon Blue Cross Blue Shield of New Jersey

## Small Employer Group Application Instructions

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### Instructions

The attached forms should be completed with the assistance of your authorized Broker or Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) Sales Representative. **Please complete all necessary forms in their entirety. Please print in ink or type your responses.**

Ensure that all areas requiring a **signature and date are complete**. The Officer, Partner, Owner and / or Correspondent signing the application must be listed on the New Jersey Small Employer Certification.

Completed enrollment application forms should be sent to your authorized Broker or Horizon BCBSNJ Sales Representative **prior to your effective date**.

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### Documents Included

Attached you will find the forms that must be completed and submitted for each New Jersey small employer group applying for standard health insurance coverage:

- Application for a Small Employer Health Benefits Policy
  - New Jersey Small Employer Certification
  - Small Employer Health Benefits Waiver of Coverage – One form is needed for each employee waiving or refusing coverage. This form may be photocopied as needed.
- 

### Other Required Documents

In addition to the forms listed above, **depending on group size / composition and preferred payment method, the following items may also be required:**

- Payroll verification through appropriate tax documentation, i.e., WR30 (required for groups of two to five eligibles)
- Spousal Business Statement (required for husband and wife-only groups) (#3268)
- Automatic Pay Plan Application (#8977)

When submitting your paperwork as required above, **you must also submit the following:**

- Enrollment Change/Request Form (#6803) – One form is needed for each employee enrolling. Your authorized Broker or Horizon BCBSNJ Sales Representative will provide these forms.
  - First month's premium – All new cases must be submitted with a company check for the first month's premium payable to Horizon BCBSNJ. If a case is submitted without a premium check, the case will be returned.
  - Prior/Current Carrier's most recent billing statement – Required if replacing group medical coverage.
  - Rate Quote – The rate quote generated for the group should match the product(s) selected in Section II of the Application for a Small Employer Health Benefits Policy.
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### Rate Quotes

The rate quote is an estimate based on information provided by your authorized Broker or Horizon BCBSNJ Sales Representative. If there is inaccurate or missing information on the original quote, the rate may change based on an official review of the paperwork submitted to Horizon BCBSNJ.

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### Mailing Instructions

Please send the completed paperwork and attachments to:

Horizon Blue Cross Blue Shield of New Jersey  
Three Penn Plaza East PP-09W  
Newark, NJ 07105-2200

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### APPLICATION FOR A SMALL GROUP HEALTH BENEFITS POLICY

Please print or type Policy number \_\_\_\_\_  New Policy  Change in Policy Requested Effective Date \_\_\_\_\_

**Note:** The Effective Date will be on or after the date Horizon Blue Cross Blue Shield of New Jersey approves the application.

**SECTION I: POLICYHOLDER INFORMATION**

1. Policyholder (full legal name of company): \_\_\_\_\_

2. Tax Identification Number: \_\_\_\_\_

3. Main Address: \_\_\_\_\_  
Street City State Zip

Mailing Address: \_\_\_\_\_  
Street City State Zip

Telephone: \_\_\_\_\_ Facsimile: \_\_\_\_\_ Email Address: \_\_\_\_\_

4. Name of Correspondent: \_\_\_\_\_ Title: \_\_\_\_\_

5. Type of Organization:  Corporation  Partnership  Proprietorship  Other (explain): \_\_\_\_\_

6. Nature of Business (specify): \_\_\_\_\_ SIC Code: \_\_\_\_\_

7. Number of eligible employees in your company: \_\_\_\_\_  
*Refer to the New Jersey Small Employer Certification for the definition of an eligible employee.*

8. Number of eligible employees to be insured: \_\_\_\_\_ 9. Class or classes to be excluded: \_\_\_\_\_

10. Insurance Requested For:  Employees Only  Employees and Dependents  
Should the plan provide coverage for domestic partners as permitted by P.L. 2003, c. 246?  Yes  No  
If yes, should the plan provide coverage for coverage of children of a covered domestic partner?  Yes  No

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

12. Is the employer subject to the requirements of Medicare as Secondary Payor Rules for eligibility due to age?  Yes  No  
Due to disability?  Yes  No

13. Waiting period before employees become insured: (may not exceed 6 months) Present employees : \_\_\_\_\_ New or Rehired Employees: \_\_\_\_\_

14. What percentage of the premium will the employer pay? \_\_\_\_\_ 15. Deposit \$ \_\_\_\_\_

Premium Paid:  Monthly  Quarterly  Automatic checking withdrawal  
Premium will be due as of the effective date. The premium for the first month of coverage must be attached.

**Affiliates, subsidiaries or branches (Must be included for purposes of participation)**

Legal Name & Location	No. of eligible employees in this company	No. of eligible employees to be insured

**SECTION II: SPECIFICATIONS FOR COVERAGE**

**Health Benefits (Select One):**

**Co-payment Options (Select One):**  \$5  \$10  \$15  \$20  \$30

**1.  Horizon HMO**

Plan Description \_\_\_\_\_

Maximum Out Of Pocket: Network \_\_\_\_\_

**2.  Horizon HMO Coinsurance Plus**

Plan Description \_\_\_\_\_

Maximum Out Of Pocket: Network \_\_\_\_\_

**3.  Horizon POS**

Plan Description \_\_\_\_\_

Maximum Out Of Pocket: Network \_\_\_\_\_ Non-Network \_\_\_\_\_

**4.  Horizon Direct Access**

Plan Description \_\_\_\_\_

Maximum Out Of Pocket: Network \_\_\_\_\_ Non-Network \_\_\_\_\_

**5.  Horizon PPO**

Plan Description \_\_\_\_\_

Maximum Out Of Pocket: Network \_\_\_\_\_ Non-Network \_\_\_\_\_

**6.  Horizon Comprehensive Plan A - E**

Plan Description \_\_\_\_\_

Maximum Out Of Pocket: \_\_\_\_\_

**7.  Prescription Drug (Select One):**

**Deductible Options (Select One):**  \$ 0  \$ 50  \$100

Retail: \$5 / \$10 Mail Order: \$0 / \$5 No Deductible

Retail: \$15 Mail Order: \$0

Retail: \$15 Mail Order: \$22.50

Retail: \$5 / \$10 / \$20 Mail Order: \$7.50 / \$15 / \$30

Retail: 50% Coinsurance Mail Order: Not Available

Retail: \$10 / \$20 / \$35 Mail Order: \$30 / \$60 / \$105

Retail: \$12 / \$25 / \$40 Mail Order: \$24 / \$50 / \$80 No Deductible This option available for Horizon HMO only

**The prescription plan options below have exclusions beyond the standard drug plan exclusions**

Retail: \$10 / \$25 / \$50 Mail Order: \$20 / \$50 / \$100

Retail: \$10 / \$35 / \$50 Mail Order: \$20 / \$70 / \$140

Retail: \$10 / 30% / 50% Mail Order: \$20 / 30% / 50%

**Note:** Prescription Drug is not available with High Deductible Plan Options or Horizon Basic Plan A.

**8.  One-Bill Option**

Select this option when purchasing multiple health products and one summary billing statement is requested.

**Note:** Replacement ID cards will be issued for existing subgroups.

**SECTION III: ALL QUESTIONS MUST BE ANSWERED**

1. Is there any Group Health Plan:
  - now in force and to be continued?  Yes  No
  - currently being applied for?  Yes  No
 If "Yes" identify the name of the Group Health Plan, give a description of the plan(s) and name of insurance carrier(s) \_\_\_\_\_  
 \_\_\_\_\_
  
2. Name of present or prior group carrier \_\_\_\_\_  
 Effective date of prior coverage \_\_\_\_\_ Cancellation/termination date \_\_\_\_\_  
 Is the coverage applied for in this application replacing other group insurance?  Yes  No  
 If "Yes", give reason \_\_\_\_\_  
 Plan being replaced :  A  B  C  D  E  HMO  HMO-POS  Dual Contract POS  Other \_\_\_\_\_
  
3. Has your firm been uninsured for 3 or more months prior to application?  Yes  No
  
4. What forms of insurance are now or were in force?  Health Benefits  
 Prescription Drugs (attach copies of Booklet/Certificate and most recent Billing Statement)
  
5. Are extended benefits provided in case of termination of health benefits?  Yes  No
  
6. To the best of your knowledge are there any current or former employees or their eligible dependents whose health insurance is being continued?  Yes  No

Please provide the following information for each current/former employee or dependent on health continuations.

Name of Employee/Dependent	Date of Birth	Type of Continuation State/Federal/Extended Benefits	Reason for Termination Disability/Other	Continuation Dates Start	End

If additional space is needed, attach a separate sheet, signed and dated.

7. To the best of your knowledge:
  - a. Are any employees or dependents presently incapacitated?  Yes  No
  - b. Are any dependent children incapable of self-support due to a physical or mental disability?  Yes  No

Additional space to explain if items 1, 2 or 3 were answered "Yes". Refer to the question number, and give details including names, where appropriate.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

8. Does the employer participate in an arrangement with a Professional Employer Organization?  Yes  No  
 (Refer to Advisory Bulletin 00-SEH-02 if you need information concerning what constitutes a Professional Employer Organization.)

**SECTION IV: SIGNATURE**

It is understood that, except as provided under applicable regulations, 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 the 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 Blue Cross Blue Shield of New Jersey by making any promises 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. 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 includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

\_\_\_\_\_

Print name of Officer, Partner, or Proprietor

\_\_\_\_\_

Signature of Officer, Partner, or Proprietor

\_\_\_\_\_

Witness to Signature

Dated at \_\_\_\_\_ on \_\_\_\_\_

**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 UNDERWRITING USE**

Approved for \_\_\_\_\_ Number of Subscribers \_\_\_\_\_

Declined

Band \_\_\_\_\_ Date \_\_\_\_\_

Underwritten By \_\_\_\_\_ Pre-Ex Applies  Yes  No

**FOR INTERNAL GROUP ENROLLMENT USE**

	HMO	POS	DA	PPO	MSA	A	B	C	D	E	Rx	Dental
Coverage Code _____ c/o _____												
TOTAL APPLICATIONS SUBMITTED												
TRANSFER FROM GROUP # _____												
REFUSALS/WAIVERS LISTING ATTACHED (IF APPLICABLE)												
EMPLOYER CONTRIBUTION												
EFFECTIVE DATE												
FUTURE RATE RENEWAL DATE												
SALES CREDITS												

\_\_\_\_\_

SALES CONSULTANT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_ ITEM NUMBER \_\_\_\_\_

APPROVED BY: \_\_\_\_\_

SALES ADMINISTRATION SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ DATE \_\_\_\_\_

\_\_\_\_\_

CONTRACT DEVELOPMENT SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ DATE \_\_\_\_\_



Horizon Blue Cross Blue Shield of New Jersey

### NEW JERSEY SMALL EMPLOYER CERTIFICATION

Legal Name and Address of Company: \_\_\_\_\_  
Name

Street City State Zip

Group Policy Number or Group Number: \_\_\_\_\_  
(if a current customer)

#### Group Health Benefits Policy Participation

**Please indicate below the number of employees by work location/State. All employees must be included, regardless of whether or not they currently have medical coverage and through whom that coverage is provided.**

Work Location (list by State)	Number of Employees				
	Full-time	Part-time	Retired	COBRA or State Continues	Other

#### For Existing Small Employer Groups in the State of New Jersey OR New Applicants

An Eligible Employee is one who works on a full-time basis with a normal work week of 25 or more hours for compensation. An employee who works less than 25 hours per week, on a temporary or substitute basis, or an employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement is not an eligible employee.

Total Number Eligible Employees \_\_\_\_\_

Total Number Eligible Employees applying / enrolling for health benefits coverage \_\_\_\_\_

Total Number Eligible Employees waiving health benefits coverage under the policy with coverage under their spouse's coverage, other than individual coverage, or any Health Benefits Plan offered by the employer \_\_\_\_\_

Total Number Eligible Employees waiving health benefits coverage under the policy without coverage under a spouse's coverage, other than individual coverage; or any Health Benefits Plan offered by the employer \_\_\_\_\_

Total Number Eligible Employees in an ineligible class or classes \_\_\_\_\_

Is your firm subject to Working Aged Provisions of federal law (TEFRA/DEFRA)?  Yes  No  
(You *may* be subject to the law if you employed 20 or more employees for 20 weeks in the current or prior calendar year)

Is your firm subject to the requirements of the federal COBRA law?  Yes  No  
(You *may* be subject to the law if you employed 20 or more employees during 50% or more of the working days during the previous calendar year).

**CERTIFICATION AS A SMALL EMPLOYER IN THE STATE OF NEW JERSEY  
IN ACCORDANCE WITH NEW JERSEY STATUTE, CHAPTER 27A OF TITLE 17B**

For a policy of Group Health Benefits Insurance

(Please sign and date appropriate section indicating whether or not you meet the definition of a small employer)

“Small Employer” means, in connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that:

- employed average of at least two, but not more than 50, eligible Employees on business days during the preceding Calendar Year and
- employs at least two Employees on the first day of the Plan Year, and
- the majority of the Employees are employed in New Jersey.

All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an employer that was not in existence during the preceding Calendar Year, the determination of whether the employer is a small or large employer shall be based on the average number of Employees that it is expected that the employer will employ on business days in the current Calendar Year.

**I certify that I qualify as a Small Employer in the State of New Jersey.**

**AND**

**I certify that the information provided to Horizon BCBSNJ and Horizon Healthcare of New Jersey is true and complete.** I understand that if the information is not complete or is not provided to Horizon BCBSNJ and Horizon Healthcare of New Jersey in a timely manner, then the health benefits coverage does not have to be offered or continued. I further understand incomplete or untrue information may void health benefits coverage.

I understand that my employees and I may be subject to fines if an employee who is a resident of New Jersey and is eligible for coverage under this group health benefits plan is enrolled in an individual health benefits plan issued on or after August 1, 1993.

\_\_\_\_\_  
*Signature of Officer, Partner, or Proprietor*

\_\_\_\_\_  
*Title*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
Print Name of Officer, Partner, or Proprietor

\_\_\_\_\_  
*Signature of Witness*

\_\_\_\_\_  
*Date*

**I certify that I am NOT a Small Employer in the State of New Jersey, as defined above.**

\_\_\_\_\_  
*Signature of Officer, Partner, or Proprietor*

\_\_\_\_\_  
*Title*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
Print Name of Officer, Partner, or Proprietor

\_\_\_\_\_  
*Signature of Witness*

\_\_\_\_\_  
*Date*

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

**COMPLETE THIS SECTION ONLY IF YOU HAVE CERTIFIED THAT YOU ARE A SMALL EMPLOYER IN THE STATE OF NEW JERSEY.**

**\*EMPLOYEE CENSUS INFORMATION**

Please include the following persons in the following list:

- a. employees, owners, partners, officers, and independent contractors who are actively working for the employer on a regular basis, and are paid by the employer on a regular basis, whether or not they are eligible to be covered under the policy.
- b. employees, owners, partners, officers, and independent contractors who are not working, but who are currently covered under the employer's health benefits plan for reasons such as continuation of coverage or total disability.

**Please use the following letters to indicate Status:**

- F:** Full-time employee who works 25 or more hours per week
- P:** Part-time employee who works less than 25 hours per week
- T:** Temporary Employee
- I:** Independent Contractor
- D:** Totally Disabled Employee
- C:** Continuee under state or federal law
- U:** Employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement.

Name	Job Title	Date of Employment	Hours Worked Per Week	Status	Work Location (State)	Gender	Date of Birth
1.							
2.							
3.							
4.							
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28.							
29.							
30.							

\*If additional space is needed, attach a separate sheet.



Horizon Blue Cross Blue Shield of New Jersey

### SMALL EMPLOYER HEALTH BENEFITS WAIVER OF COVERAGE

Group Policy No.: \_\_\_\_\_

Policyholder Name: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Marital Status:  Single  Married  Widowed  Divorced

Date of Employment: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I was given the opportunity to enroll in this plan of group health benefits offered by my employer and insured by Horizon Blue Cross Blue Shield of New Jersey, Inc. I *refuse* the following:

- Employee, Spouse, and Child(ren) coverage
- Spouse coverage
- Child(ren) coverage

*Reason for Refusal (Please check all appropriate boxes.)*

- other fully-insured Group Health Plan sponsored by this employer
- other Group Health Plan sponsored by my spouse's employer
- other group coverage sponsored by another organization
- covered under Medicare
- other reasons (please explain) \_\_\_\_\_

Please identify Group Health Plan(s) and provide names(s) of Policyholder(s), carrier(s) and policy number(s).

Policyholder/Name: \_\_\_\_\_

Carrier: \_\_\_\_\_ Policy number: \_\_\_\_\_

Policyholder/Name: \_\_\_\_\_

Carrier: \_\_\_\_\_ Policy number: \_\_\_\_\_

Policyholder/Name: \_\_\_\_\_

Carrier: \_\_\_\_\_ Policy number: \_\_\_\_\_

If you are declining enrollment for yourself or your dependents (including your spouse) because of other Group Health Plan coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents provided, that you request enrollment within 30 days after marriage, birth, adoption or placement for adoption.

If the reason for the refusal of coverage is coverage under another Group Health Plan, it is important to provide information concerning that Group Health Plan on this Waiver of Coverage form. If you fail to provide this information on this Waiver of Coverage form and you later become ineligible for such other coverage and then wish to enroll in any of the refused coverages, you will be considered a Late Enrollee and may be subject to the pre-existing conditions exclusion.

I understand that if I later wish to enroll for any of the coverage(s) refused, I will be required to submit an Enrollment Form and coverage may be subject to a pre-existing conditions exclusion.

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date



Horizon Blue Cross Blue Shield of New Jersey

### EMPLOYMENT VERIFICATION FORM FOR GROUPS TWO TO FIVE ELIGIBLE

As a result of New Jersey Insurance Reform, mandated regulations govern the way in which Horizon Blue Cross Blue Shield of New Jersey issues and administers insurance policies. The criteria for eligibility regarding the creation and maintenance of a Small Group Plan may be found in Regulations @ N.J.A.C. 11:21 et seq.

I understand that pursuant to these Regulations, no individual shall become insured who is not a bona fide employee working on a full-time, compensated basis. Only full-time, compensated employees are eligible for coverage. A full-time compensated employee is one who regularly works at least 25 hours per week at the employer's place of business for compensation.

I, \_\_\_\_\_, an Accountant/Attorney in the State of New Jersey, do hereby certify that I am the accountant for

\_\_\_\_\_ Inc.

I am EMPLOYED by: (provide name, address and telephone number of firm)

\_\_\_\_\_

I further certify that the following list of people are employees of the above listed company and fully meet the definition of "full-time employee" as set forth by the State of New Jersey in Regulations @ N.J.A.C. 11:21 et seq. The SEH reform policies, applications, etc. are standard forms published as Regulations @ N.J.A.C. 11:21 et seq., wherein the rules governing the reform market can be found.

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_

(Attach additional sheet if required - sign each additional sheet.)

I further certify that the information I have provided is accurate, complete and true. I understand the omission of facts or the material misrepresentations of a fact, is a violation of N.J.S.A. 17B:27A-23 et seq. and 17:33A, New Jersey Fraud Prevention Act, as well as 2C:21-4.3.C, Healthcare Claims Fraud with criminal and civil penalties attached.

PRINT NAME

SIGNATURE

DATE



Horizon Blue Cross Blue Shield of New Jersey

### EMPLOYMENT VERIFICATION FOR HUSBAND/WIFE GROUPS

As a result of New Jersey Insurance Reform, mandated regulations govern the way in which Horizon Blue Cross Blue Shield of New Jersey issues and administers insurance policies. The criteria for eligibility regarding the creation and maintenance of a Small Group Plan may be found in Regulations @ N.J.A.C. 11:21 et seq.

I understand that pursuant to these Regulations, no individual shall become insured who is not a bona fide employee working on a full-time, compensated basis. Only full-time, compensated employees are eligible for coverage. A full-time compensated employee is one who regularly works at least 25 hours per week at the employer's place of business for compensation.

I, \_\_\_\_\_, do hereby certify that:

\_\_\_\_\_ and \_\_\_\_\_ are

EMPLOYEES OF: \_\_\_\_\_ which is

located at: \_\_\_\_\_

I further certify that both parties fully meet the definition of "full-time employee" as set forth by the State of New Jersey in Regulations @ N.J.A.C. 11:21 et seq.

I understand that if the information I have provided is not accurate, complete and true, or if I have omitted any facts or made any material misrepresentations of a fact, I may be in violation of N.J.S.A. 17B:27A-23 et seq. and 17:33A, New Jersey Fraud Prevention Act, as well as 2C:21-4.3.C, Healthcare Claims Fraud with criminal and civil penalties attached. In addition, I understand that if I omit material facts or provide false information my contract can be terminated as of the original effective date.

I have read this document and affix my signature.

\_\_\_\_\_  
PRINT NAME – WIFE

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINT NAME – HUSBAND

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE



Horizon Blue Cross Blue Shield of New Jersey

## GENERAL NOTICE OF PREEXISTING CONDITIONS EXCLUSION

Your group health plan imposes a preexisting conditions exclusion that applies to persons who do not enroll as of the plan's effective date or during the plan's open enrollment period. If it applies to you, this exclusion means that if you or a covered dependent (if your plan includes coverage for dependents) has a medical condition before coverage under this plan starts, you or the dependent may have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within a six-month period (or any lesser period that this plan elects). Generally, this "look-back period" ends the day before the person's coverage under this plan becomes effective. However, if the person is in a waiting period for coverage imposed by the plan, the "look-back period" ends on the day before the waiting period begins.

This exclusion does not apply to pregnancy or to a child (if dependents' coverage applies) who is enrolled in the plan within 31 days after birth, adoption or placement for adoption.

Federal rules provide that this exclusion cannot last for more than 12 months (18 months for late enrollees) from the first day of coverage, or, if a waiting period applies, from the first day of the waiting period. However, your employer may have chosen a lesser period for this exclusion. The length of the preexisting conditions exclusion period can be reduced by the number of days of your or your dependent's prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the length of this exclusion, provided that you or the dependent has not experienced a break in coverage of 63 days or more that extends from the termination of the prior health coverage to the effective date of his/her coverage under this plan.

To reduce the applicable length of this exclusion by creditable coverage, you must provide the plan with a copy of any certificates of creditable coverage that you have. There are also other ways that you can prove prior creditable coverage.

If the exclusion applies to you, you will receive full details about it in other plan materials that you will receive. In the meantime, if you have questions about this exclusion, or if you need help demonstrating creditable coverage, contact your benefits department or personnel representative.



Horizon Blue Cross Blue Shield  
of New Jersey

### LATE PAPERWORK FORM

**Agents:** If you are submitting group enrollment paperwork 14 calendar days (or less) prior to the group's requested effective date, this form must be filled out by the group administrator, signed and submitted with their **complete** paperwork to either our Newark or Marlton offices.

Group: \_\_\_\_\_

Address: \_\_\_\_\_

We the undersigned understand that we are requesting a coverage date that will put our enrollment paperwork in Horizon BCBSNJ's home office(s) 14 days (or less) prior to our effective date, and that delivery of our I.D. cards and system activation will occur after our effective date.

Upon approval of our request for insurance, we acknowledge that the delivery of our group I.D. cards and system activation may occur after our effective date.

Name (please print): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



Horizon Blue Cross Blue Shield of New Jersey

### AUTOMATIC PAY PLAN APPLICATION

#### Agreement Authorizing Horizon Blue Cross Blue Shield of New Jersey to Debit Checking Account

This agreement is made between Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ)

and \_\_\_\_\_  
(name of depositor as shown on bank records)

Horizon BCBSNJ is hereby requested and authorized to initiate deductions from the group's checking account listed below. The named banking institution (Bank) is hereby requested and authorized to charge such deductions to the checking account below.

Bank Name \_\_\_\_\_ Bank Account No. \_\_\_\_\_

Bank Address \_\_\_\_\_  
(address of branch where account is maintained)

It is understood and agreed that:

- (1) The Group's bank account listed above will be debited as required to pay premiums for the group's health benefits contract with Horizon BCBSNJ on the premium due date.
- (2) If a debit is refused by the Bank for any reason other than the Bank's error, it will be determined that payment of the premium has not been tendered by the group and the group's health benefits contract with Horizon BCBSNJ will be in arrears and subject to termination in accordance with its terms.
- (3) This agreement and authorization shall remain in effect until 30 days after both Horizon BCBSNJ and the Bank receive written notification from the group of its termination or until the group's health benefits contract with Horizon Blue Cross Blue Shield of New Jersey is terminated for any reason.

Group Name \_\_\_\_\_ Group Number \_\_\_\_\_

Date \_\_\_\_\_ Signed \_\_\_\_\_ Title \_\_\_\_\_

**IMPORTANT:** Please attach a blank, voided check for the bank account from which deductions should be made, and mail to:

Horizon Blue Cross Blue Shield of New Jersey  
3 Penn Plaza East PP-06A  
Newark, New Jersey 07105-2200



Horizon Blue Cross Blue Shield of New Jersey

# GROUP ENROLLMENT/CHANGE REQUEST

Attn: Small Group Enrollment  
P.O. Box 607 Department A  
Newark, NJ 07101-0607  
Fax (973) 274-2227  
www.HorizonBlue.com

**Group Information – to be completed by Employer.**

Group Name: \_\_\_\_\_ Group Number: \_\_\_\_\_

Sub Group Number: \_\_\_\_\_

Date of Hire: \_\_\_\_/\_\_\_\_/\_\_\_\_ Effective Date/Date of Event: \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason: \_\_\_\_\_

**A. Type of Activity – to be completed by Employer.**

*Refer to instructions before completing this form. Print clearly.*

ADD  REMOVE  OTHER CHANGE

	Effective Date/Date of Event	Reason for Change
<input type="checkbox"/> Subscriber	____/____/____	_____
<input type="checkbox"/> Spouse	____/____/____	_____
<input type="checkbox"/> Civil Union Partner (CUP)/Domestic Partner (DP)	____/____/____	_____
<input type="checkbox"/> Dependent Child	____/____/____	_____
<input type="checkbox"/> Over-Age Child as a Dependent Under 30 <i>(please complete section B, if applicable)</i>	____/____/____	_____
<input type="checkbox"/> Name Change	____/____/____	_____
<input type="checkbox"/> Change Plan	____/____/____	_____
<input type="checkbox"/> Other	____/____/____	_____

**COVERAGE CONTINUATION**

For Employee Billing:  Group

Date of Loss of Coverage \_\_\_\_/\_\_\_\_/\_\_\_\_ Qualifying Event #\*\* \_\_\_\_\_ Date of Qualifying Event \_\_\_\_/\_\_\_\_/\_\_\_\_

Total Disability\*  COBRA/NJSGC Length of Continuation (in months):  18  29

*\*Attach proof of disability*

For Spouse/Civil Union Partner\*/Domestic Partner Billing:  Group

Date of Loss of Coverage \_\_\_\_/\_\_\_\_/\_\_\_\_ Qualifying Event #\*\* \_\_\_\_\_ Date of Qualifying Event \_\_\_\_/\_\_\_\_/\_\_\_\_

COBRA/NJSGC\* Length of Continuation (in months):  18  29  36

*\*Civil union partners are eligible to make an election pursuant to NJSGC, if applicable.*

For Dependent or Over-aged Child Billing:  Group

Date of Loss of Coverage \_\_\_\_/\_\_\_\_/\_\_\_\_ Qualifying Event #\*\* \_\_\_\_\_ Date of Qualifying Event \_\_\_\_/\_\_\_\_/\_\_\_\_

COBRA/NJSGC Length of Continuation (in months):  18  29  36

Dependent Under 30 Billing:  Home

Date of Loss of Coverage \_\_\_\_/\_\_\_\_/\_\_\_\_ Qualifying Event #\*\* \_\_\_\_\_ Date of Qualifying Event \_\_\_\_/\_\_\_\_/\_\_\_\_

Home Address: \_\_\_\_\_

*\*\*Qualifying event #: see list in Instructions.*

**B. Additional Information for Dependent Under 30 Continuation Elections.**

*Provide information below about children listed in Section F for whom a Dependent Under 30 continuation election is being made.*

This Continuation Election is being made:

During an Open Enrollment period for the Over-Age Child based on his/her age-out anniversary

Within 30 days prior to the attainment of the limiting age (when the Dependent will become an Over-Age Child)

Within 30 days after the Over-Age Child has established eligibility for a Chapter 375 Continuation Election

**C. Employee Information – to be completed by Employee.**

ADD  REMOVE  CONTINUATION  OTHER CHANGE

*If a name change, indicate prior name: \_\_\_\_\_*

Last Name, First Name, M.I. \_\_\_\_\_

Social Security# \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex \_\_\_\_\_

Home Address \_\_\_\_\_ Apt \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone \_\_\_\_\_ E-Mail Address \_\_\_\_\_

Employer Name \_\_\_\_\_ Employment Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ Hours Per Week \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_ Work Phone \_\_\_\_\_ E-Mail Address \_\_\_\_\_

Primary Care Provider Name \_\_\_\_\_ Current Patient  Yes  No

NPI # \_\_\_\_\_ Loc Code \_\_\_\_\_

Other Health Coverage  Yes  No, If yes, Payer Name \_\_\_\_\_

Policy # \_\_\_\_\_ Medicare ID #, If any \_\_\_\_\_

Previous Coverage  Yes  No, If yes, Payer Name \_\_\_\_\_

Policy # \_\_\_\_\_ Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Termination Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Submit a copy of the Certificate of Creditable Coverage**

**D. Race/Ethnicity – to be completed by the Employee, at his/her option.**

NOTE: Your response is appreciated but NOT required! *Choose a category that most closely describes you:*

American Indian or Alaskan Native  Black, not of Hispanic origin

Hispanic  Asian or Pacific Islander  White, not of Hispanic origin

**E. Plan Option – to be completed by the Employee.**

*Check one Coverage Option Box and one Plan Option Box*

Medical  S  F  H/W  CUP  DP  P/C

Dental  S  F  H/W  CUP  DP  P/C

Prescription  S  F  H/W  CUP  DP  P/C

Horizon Traditional  Horizon Direct Access  Horizon Direct Access (HSA)

Horizon POS  Horizon PPO (HSA)  Prescription

Horizon PPO  Horizon HMO  Other \_\_\_\_\_

S = Single F = Family H/W = Husband/Wife CUP = Civil Union Partners DP = Domestic Partners P/C = Parent/Child(ren)

The Employee Copy of this application may be used as a temporary ID card for thirty days from the effective date if authorized by Employer. Coverage must be verified with Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc. prior to visiting a physician or admission to a hospital.

**F. Other Individuals Covered – to be completed by Employee.**

Identify individuals other than yourself for whom you are adding/changing/removing/ continuing coverage. Attach additional pages if necessary, with your signature and dated. Attach proof if full-time post-secondary student. Attach proof of disability.

**SPOUSE/CUP/DP**  ADD  REMOVE  CONTINUE SPOUSE (COBRA/NJSGC)  
 CONTINUE CU PARTNER (NJSGC)  CONTINUE DP (COBRA/NJSGC)

Last Name, First Name, M.I. \_\_\_\_\_

Social Security# \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex \_\_\_\_\_

Primary Care Provider Name \_\_\_\_\_ Current Patient  Yes  No

NPI # \_\_\_\_\_ Loc Code \_\_\_\_\_

Other Health Coverage  Yes  No, If yes, Payer Name \_\_\_\_\_

Policy # \_\_\_\_\_ Medicare ID #, If any \_\_\_\_\_

Previous Coverage  Yes  No, If yes, Payer Name \_\_\_\_\_

Policy # \_\_\_\_\_ Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Termination Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Employed?  Yes  No *If yes, Complete Section H*

*Submit a copy of the Certificate of Creditable Coverage*

**1. Child**  ADD  REMOVE  CONTINUATION  OTHER CHANGE

Last Name, First Name, M.I. \_\_\_\_\_

Social Security# \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex \_\_\_\_\_

Primary Care Provider Name \_\_\_\_\_ Current Patient  Yes  No

NPI # \_\_\_\_\_ Loc Code \_\_\_\_\_

Other Health Coverage  Yes  No, If yes, Payer Name \_\_\_\_\_

Policy # \_\_\_\_\_ Medicare ID #, If any \_\_\_\_\_

Previous Coverage  Yes  No, If yes, Payer Name \_\_\_\_\_

Policy # \_\_\_\_\_ Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Termination Date \_\_\_\_/\_\_\_\_/\_\_\_\_

If last name is different from Employee's, please explain: \_\_\_\_\_

Living with Employee?  Yes  No *If no, Complete Section I*

*Submit a copy of the Certificate of Creditable Coverage*

**2. Child**  ADD  REMOVE  CONTINUATION  OTHER CHANGE

Last Name, First Name, M.I. \_\_\_\_\_

Social Security# \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex \_\_\_\_\_

Primary Care Provider Name \_\_\_\_\_ Current Patient  Yes  No

NPI # \_\_\_\_\_ Loc Code \_\_\_\_\_

Other Health Coverage  Yes  No, If yes, Payer Name \_\_\_\_\_

Policy # \_\_\_\_\_ Medicare ID #, If any \_\_\_\_\_

Previous Coverage  Yes  No, If yes, Payer Name \_\_\_\_\_

Policy # \_\_\_\_\_ Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Termination Date \_\_\_\_/\_\_\_\_/\_\_\_\_

If last name is different from Employee's, please explain: \_\_\_\_\_

Living with Employee?  Yes  No *If no, Complete Section I*

*Submit a copy of the Certificate of Creditable Coverage*

**G. Preexisting Conditions – to be completed by Employee.**

Complete if you are a new enrollee except when enrolling in a Small Employer Group health benefits plan with more than 5 employees. Complete for all late enrollees. If you check one of the conditions in #1, or respond yes to any question in #2, give details on a separate sheet of paper. This separate sheet must be signed and dated by you. This information may ONLY be used to determine if a condition is a pre-existing condition. You CANNOT be denied coverage under a health benefits plan on the basis of accurate responses to the following questions. Carriers may only use the information to expedite the processing of claims.

**1. If you or any dependent to be covered has been diagnosed as having any of the following within the past 6 months, please place a check mark in the appropriate box:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> a. Alcoholism or Drug Abuse              | <input type="checkbox"/> f. Diabetes                            | <input type="checkbox"/> k. Lung or Respiratory Disorder  |
| <input type="checkbox"/> b. Arthritis                             | <input type="checkbox"/> g. Gastro or Intestinal Disorder       | <input type="checkbox"/> l. Mental or Nervous Disorder    |
| <input type="checkbox"/> c. Blood Disorder                        | <input type="checkbox"/> h. Heart Disorder/Condition/Chest Pain | <input type="checkbox"/> m. Paralysis, Stroke or Epilepsy |
| <input type="checkbox"/> d. Back or Neck Disorder, Injury or Pain | <input type="checkbox"/> i. High Blood Pressure                 |   |
| <input type="checkbox"/> e. Cancer or Tumors                      | <input type="checkbox"/> j. Kidney or Liver Disorder            |   |

**2. During the past 6 months, have you or any dependent to be covered:**

- |  |                          |                          |
|--|--------------------------|--------------------------|
| a. been examined or treated by a physician or other health care provider for any condition, illness or injury, other than as stated above? | Yes                      | No                       |
| b. been advised to have treatment or surgery or testing that has not been done?  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. been admitted to a hospital or other health care facility as an inpatient?  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. taken prescribed medication?  | <input type="checkbox"/> | <input type="checkbox"/> |

**H. Additional Spouse/CUP/DP Information – to be completed by Employee.** *If not applicable mark as N/A.*

Employer Name \_\_\_\_\_ Employer Phone \_\_\_\_\_

Employer Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**I. Additional Child Information – to be completed by Employee.**

Provide information below about children listed in Section F, if they have a different address from the employee. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.

Name \_\_\_\_\_

Address \_\_\_\_\_ Apt \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Reason: \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_ Apt \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Reason: \_\_\_\_\_

**J. Employee Signature**

I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I authorize deductions from my earnings for any contributions required from me.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**K. Over-Age Child's Signature**

I represent that all the information supplied in this application regarding the Dependent Under 30 Continuation Election is true and complete.

I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I hereby agree to make premium payments required from me for the Dependent Under 30 Continuation Election.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**L. Employer Verification**

The requested activity is believed eligible and is approved by the Employer:  Yes  No

Employer Representative: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Representative's Title: \_\_\_\_\_

## Instructions

### Employers

You must complete the Employer Group Information and sections A, B, and L in order for this application to be processed.

### Employees

You must complete sections C through J and submit the signature of each Over-Age Child for which a Dependent Under 30 Continuation Election is made in accordance with Section B in order for this application to be processed.

- Please PRINT except when a signature is requested.
- If a dependent is disabled and you want to continue his or her coverage beyond the limiting age, you do not have to make a COBRA/NJSGC or Dependent Under 30 election. Instead, select “Other” in Section A, and attach proof of disability.
- If a dependent is a full-time post-secondary student, you must attach a current course schedule or a letter from the school or its authorized representative confirming full-time student status.
- You can obtain the providers’ correct names and addresses from the appropriate provider directory. You may also obtain each provider’s NPI and LOC Code number from the provider directory or at: [www.horizonblue.com](http://www.horizonblue.com). Providers with multiple office locations and individual providers who belong to more than one practice or provider entity may have more than one NPI number. You should confirm the correct NPI number for the specific provider and office location where you will be seen by contacting that office directly.

### Qualifying Events

COBRA and NJSGC

- C1. Termination of job or reduction in hours
- C2. Employee enrollment in Medicare (COBRA only)
- C3. Divorce (COBRA/NJSGC); civil union dissolution (NJSGC) or termination of domestic partnership (COBRA/NJSGC)
- C4. Death of employee
- C5. Loss of dependent child status under the plan.
- C6. Disability (occurring subsequent to another qualifying event)

Dependent Under 30

- D1. Loss of dependent status and otherwise eligible
- D2. Reestablish eligibility: residency
- D3. Reestablish eligibility: nonresident full-time student
- D4. Reestablish eligibility: change in marital status
- D5. Reestablish eligibility: change in parental status
- D6. Reestablish eligibility: termination of other coverage

## Conditions of Enrollment - Applicant Acknowledgements and Agreements

On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer reporting agency, and any employer to give Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc., or any consumer reporting agency acting on behalf of Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc., information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc. has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one.
4. I agree Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc. will provide coverage in accordance with the terms of the contract for the group plan/policy.
5. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the group plan/policy if premiums are not paid timely. I authorize my Employer to withhold payments from my wages as contribution to the premium, as appropriate.

### Misrepresentations

Any person who includes any false or misleading information on an Enrollment/Change Request Form for a health benefits plan is subject to criminal and civil penalties.

**BULLETIN NO. 08-16**

**TO: ALL NEW JERSEY LICENSED INSURERS TRANSACTING HEALTH INSURANCE BUSINESS; HOSPITAL, MEDICAL HEALTH AND DENTAL SERVICE CORPORATIONS; DENTAL PLAN ORGANIZATIONS, PREPAID PRESCRIPTION PLANS AND HEALTH MAINTENANCE ORGANIZATIONS; ALL NEW JERSEY LICENSED HEALTH INSURANCE PRODUCERS**

**FROM: STEVEN M. GOLDMAN, COMMISSIONER**

**RE: PRODUCER COMPENSATION DISCLOSURES**

P.L. 2008, c. 38 (the Act), was approved on July 8, 2008 and becomes effective on January 5, 2009. Among other things, section 25 of the Act amends the New Jersey Producer Licensing Act of 2001 (codified at N.J.S.A. 17:22A-26 et seq.) by requiring licensed insurance producers to disclose to health insurance purchasers any compensation received from the sale of such policies or contracts. Section 25 of the Act states:

a. An insurance producer licensed pursuant to P.L. 2001, c. 210 (C. 17:22A-26 et seq.) who sells, solicits, or negotiates health insurance policies or contracts to residents of this State shall notify the purchaser of the insurance, in writing, of the amount of any commission, service fee, brokerage, or other valuable consideration that the producer will receive as a result of the sale, solicitation or negotiation of the health insurance policy or contract. If the commission, fee, brokerage, or other valuable consideration is based on a percentage of premium, the insurance producer shall include that information in the notification to the purchaser.

b. The commissioner may specify, by regulation, the information that shall be provided by an insurance producer in the notification to a purchaser of health insurance and the procedure for providing the notification.

N.J.S.A. 17:22A-28 defines an "insurance producer" as a person required to be licensed under the laws of this State to sell, solicit or negotiate insurance. The term includes insurance brokers, agents and consultants, and general agents.

The purpose of this Bulletin is to notify producers, and carriers who compensate producers, of the requirements of Section 25 of the Act and to clarify the Department's position concerning implementation of this section pending the Department's proposal of regulations.

- **Scope of Disclosure:** Disclosure is required for any insurance contract that meets the definition of "health insurance" at N.J.S.A. 17B:17-4 and for any contract sold by non-insurance health carriers, such as hospital, medical, health and dental service corporations; dental plan organizations, prepaid prescription plans and health maintenance organizations. Disclosure is not required for health coverage that is an incidental part of a life or annuity contract.

- **What must be Disclosed:** Any valuable consideration, including but not limited to commissions or service fees, must be disclosed. Consideration must be disclosed even if its amount cannot be calculated or estimated. However, the precise nature of the compensation (e.g., commission vs. service fee) does not need to be disclosed. In the case of standard

commission rates, the commission percentage or the per employee amount of commission in connection with a rate proposal, binder or bill may be disclosed.

- **Who Provides Disclosure:** The Act requires that the producer provide the disclosure to the insurance purchaser, however in many cases it may be more efficient for the carrier to provide the disclosure.

- **Timing of Disclosure:** The Act does not imply that disclosure must be made at the time of proposal or prior to a contract becoming effective. Disclosure should be made no later than the effective date of the contract.

- **Form of Disclosure:** Attached is a suggested form that may be used for compliance with the Act's compensation disclosure requirements. Use of an alternate form is acceptable so long as the Act's written compensation disclosure requirements are met.

10/01/08  
Date

/s/ Steven M. Goldman, Commissioner  
Steven M. Goldman, Commissioner

Inoord/bbProducerComp

**DISCLOSURE OF A FINANCIAL INTEREST  
IN THE SALE OF HEALTH INSURANCE POLICIES**

New Jersey law (N.J.S.A. 17:22A-41.1) requires disclosure of the compensation a licensed agent or broker (producer) receives from your purchase or renewal of health coverage. Compensation may be in the form of a commission, fee(s), or possibly other valuable consideration, or a combination of all three.

The per employee dollar amount(s) or percentage(s) of premium are in the table below. All amounts and/or percentages are additive. If something does not apply, it is marked "None" or "NA". If there is compensation, whether or not in addition to the compensation shown, whose amount cannot be determined, enter "CBD" (cannot be determined) on the appropriate line. Use the "Other" line for all other compensation, whether or not the amount is determinable.

	Agent/Producer	
	Percentage (%)	Amount in Dollars (\$) (per employee basis)
Commission of Issuing Agent		
Commission of General Agent		
Consultant Fee		
Brokerage Fee		
Other:		

**PRODUCER INFORMATION**

Agent Name: \_\_\_\_\_

General Agent Name: \_\_\_\_\_

**CARRIER INFORMATION**

Company Name: \_\_\_\_\_

\_\_\_\_\_  
Date

[ \_\_\_\_\_  
Agent/Producer Signature]<sup>1</sup>

<sup>1</sup>Carriers: omit this signature block if sending the disclosure form directly to the purchaser.

## Notices

### General Notice of Special Enrollment Rights

If you are declining enrollment under your group health plan for yourself and/or your dependents (if your plan includes coverage for dependents) because of other health insurance or other group health plan coverage, you may be able to enroll yourself and those dependents in this group health plan if you or the dependents lose eligibility for that other coverage (or if the other employer stops contributing toward your or your dependents' other coverage). However, if the other coverage was continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you must request enrollment within 30 days after the COBRA coverage ends. If the other coverage was not COBRA continuation coverage, you must request enrollment within 90 days after your or your dependents' other coverage ends (or after the other employer stops contributing toward the other coverage).

In addition, if this plan includes coverage for dependents and you acquire a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents under this plan after declining its coverage. However, you must request enrollment within 31 days after the child's birth or within 30 days after the marriage, adoption or placement for adoption.

If you decline group health coverage under this plan, you will be asked to state in writing whether the declination was due to the existence of other health coverage. If you don't provide this statement, the above special enrollment rights may not be available to you if you need them.

To request special enrollment or obtain more information about it, contact your benefits manager, if available, or your employer.

### General Notice of Preexisting Conditions Exclusions

**NOTE:** Your plan imposes a "preexisting conditions exclusion." As described below, the details of the exclusion that your plan has differ depending on the number of eligible employees in your group. Contact your benefits manager, if available, or employer for this information.

#### Small Employers with five or fewer eligible employees

A "preexisting conditions exclusion" means that if you or a covered dependent (if your plan includes coverage for dependents) has a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for the condition. This limitation only applies to a condition which manifests itself during the six-month period immediately preceding your or your dependent's enrollment date and for which medical advice, diagnosis, care or treatment was recommended or received during the six-month period immediately preceding that date.

The enrollment date means, with respect to an employee or dependent, the earlier of the effective date of his/her coverage under the group health plan, or the first day of the waiting period, if any, for such enrollment.

#### Small Employers with more than five eligible employees

In this case, your plan only imposes a preexisting conditions exclusion on employees and dependents (if the plan includes coverage for dependents) who are late enrollees. A late enrollee is:

- an employee or dependent (other than a newborn or an adopted child) who enrolls or is enrolled more than 30 days after first becoming eligible;
- or

- a newborn or adopted child whom you enroll more than 31 days after the child's birth, adoption or placement for adoption.

This means that if you or your dependent is a late enrollee and has a medical condition before coming to our plan, you will have to wait a certain period of time before the plan will provide coverage for that condition. This limitation only applies to a condition which manifests itself during the six-month period immediately preceding your or your dependent's enrollment date and for which medical advice, diagnosis, care or treatment was recommended or received during the six-month period immediately preceding that date. The "enrollment date" is the effective date of your or your dependent's coverage under the group health plan.

### All Small Employers

A preexisting conditions exclusion does not apply to pregnancy. In addition, it does not apply to:

- a child who is covered under any creditable coverage within 31 days of birth adoption or placement of adoption as long as there is not a significant break in coverage of more than 90 consecutive days prior to the child's enrollment date;
- or
- birth defects in a covered dependent child.

This plan will not provide benefits for preexisting conditions for 180 days, measured from the person's enrollment date. However, the length of this period can be reduced by the number of days of your or your dependent's prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the length of this exclusion, provided that you or your dependent has not experienced a break in coverage of 90 days or more.

To reduce the length of this exclusion by creditable coverage, you must provide the plan with a copy of any certificates of creditable coverage that you have. There are also other ways that you can prove prior creditable coverage.

If you have questions about the preexisting conditions exclusion, or if you need help demonstrating creditable coverage, contact your benefits manager, if available, or your employer.

### Notice on Dependent Under 30 Continuation

Horizon Blue Cross Blue Shield of New Jersey will bill over- age dependents directly and enrollees will remit the premium directly to Horizon. When Dependent Under 30 Continuation is selected, the home address must be completed under Section "A – Type of Activity" even when it is the same as the employee's address.

#### *Important Note:*

- Although the employee must continue eligibility under the dependent's plan for continued coverage of the dependent, in addition to the additional applicable eligibility criteria, coverage for the dependent will be issued as stand-alone coverage. All cost-sharing requirements and limitations will apply and will not be combined with the employee's policy. Consequently, covered expenses incurred by the over-age dependent will not contribute to family deductibles and out-of-pocket maximums, nor will family incurred expenses contribute to the over-age dependent's deductibles or out-of-pocket maximums.