Horizon Blue Cross Blue Shield of New Jersey

Small Employer Group Application Instructions

Instructions

The attached forms should be completed with the assistance of your authorized Broker or Horizon Blue Cross Blue Shield of New Jersey 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.**

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 five or fewer eligible).
- 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.

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.

Mailing Instructions

Please send the completed paperwork and attachments to:

Horizon Blue Cross Blue Shield of New Jersey
Three Penn Plaza East PP-13T
Newark, NJ 07105-2200

Horizon Blue Cross Blue Shield of New Jersey

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: _____

   Contract information should be provided ☐ electronically or ☐ hard copy. Check one.

4. 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 including Spouse ☐ Employees and Dependents excluding Spouse

    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. Orientation Period? ☐ Yes ☐ No

14. Waiting period before employees become insured: (may not exceed 90 days)
    Present Employees : ☐ no waiting period ☐ one month ☐ two months ☐ 90 days
    New or Rehired Employees: ☐ no waiting period ☐ one month ☐ two months ☐ 90 days

15. Period for Annual Employee Open Enrollment Period: _____

16. What percentage of the premium will the employer pay? _____

17. Deposit $ _____

Premium Paid: ☐ Monthly ☐ 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

Please select desired health benefits option, prescription drug option and stand alone pediatric dental option.

HEALTH BENEFITS

☐ **Advantage Direct Access 100/70 - $20/40 copay with Blue Card**

☐ **Advantage Direct Access 100/80/60 - $20/40 copay with Blue Card**

☐ **Advantage EPO 100% - $20/40 copay**
☐ **with Blue Card** ☐ **without Blue Card**

☐ **Advantage EPO 100% - $30/50 copay**
☐ **with Blue Card** ☐ **without Blue Card**

☐ **Advantage EPO 100/80 - $20/40 copay**
☐ **with Blue Card** ☐ **without Blue Card**

☐ **Advantage EPO 100/70 - $30/50 copay**
☐ **with Blue Card** ☐ **without Blue Card**

☐ **Advantage EPO 100/50 - $30/50 copay**
☐ **with Blue Card** ☐ **without Blue Card**

☐ **PCMH Advantage EPO 100/80 - $5/20/40 copay without Blue Card**

☐ **PCMH Advantage EPO 100/70 - $20/$30/70% without Blue Card**

☐ **PCMH Advantage EPO 100/50 - $40/50%/50% without Blue Card**

☐ **PCMH Advantage EPO 100/50 - $30/50 copay without Blue Card**

☐ **HSA Advantage Direct Access 100/80/60 - $30/50 copay with Blue Card**

☐ **HSA Advantage EPO 100% $30/50 copay**
☐ **with Blue Card** ☐ **without Blue Card**

☐ **Other:** _____

PRESCRIPTION DRUG (select according to Medical/RX package):

☐ **$10/$25/$50** ☐ **$15/$40/$75** ☐ **$10/60%/50%** ☐ **$15/60%/50%** ☐ **60% CDHRX** ☐ **50% CDHRX**

STAND ALONE PEDIATRIC DENTAL

☐ Horizon Young Grins

STAND ALONE PEDIATRIC DENTAL OPTIONS

The Patient Protection and Affordable Care Act (PPACA) permits plans outside of the Health Insurance Marketplace and the Small Employer Business Health Options (SHOP) Program to issue coverage without pediatric dental benefits only if reasonably assured that the applicant has purchased an exchange-certified stand-alone dental plan (SAPD) covering the pediatric dental benefits as required by PPACA. In order to receive reasonable assurance from you, we require the following information if you did not select the Stand Alone Pediatric Dental Plan listed above:

☐ Proof of coverage or other documentation reasonably acceptable to the Health Insurance Issuers evidencing your enrollment in an exchange certified SAPD. Proof acceptable may be a copy of enrollment confirmation from the SAPD issuer or a copy of your coverage document (for example, a certificate of coverage).

☐ The contact information of your SAPD issuer that we may verify your enrollment with, which you expressly grant our ability to verify your enrollment:

Name of SAPD Issuer: _____

Policy Number: _____

Name of Contract Holder: _____

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: _____

3. Are extended benefits provided in case of termination of health benefits? ☐ Yes ☐ No

4. 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.

5. 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.

_____

_____

_____

_____

_____

_____

_____

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_____

_____

_____

_____

_____

6. 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: AGENT/PRODUCER INFORMATION AND UNDERWRITING GROUP ENROLLMENT USE

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

Underwritten By _____ Date _____

For Internal Group Enrollment Use

	ADV DA	ADV EPO	PCMH ADV EPO	HSA ADV	HSA ADV EPO	OTHER	Rx	DENTAL	SAPD
COVERAGE CODE c/o									
TOTAL APPLICATIONS SUBMITTED									
TRANSFER FROM GROUP # _____									
REFUSALS/WAIVERS LISTING ATTACHED (IF APPLICABLE)									
EMPLOYER CONTRIBUTION									
EFFECTIVE DATE									
FUTURE RATE RENEWAL DATE									

APPROVED BY: _____ _____

REVIEWER SIGNATURE DATE APPROVED

SECTION V: 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. (Refer to the definition on the New Jersey Employer Certification.) 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 Blue Cross Blue Shield of New Jersey 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. Final rates will be based on enrollment data as of the Policy effective date. No contract of insurance is to be implied in any way on the basis of the completion and/or submission of this application.

☐ Please read this statement and check to confirm. I confirm that I have received the Summary of Benefits and Coverage (SBC) documents associated with the plan or plans I selected on this application. I confirm I will provide SBCs to plan participants and beneficiaries as required by federal regulations and guidance related to the distribution of the SBC, including the requiring for timing and delivery.

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

Dated at _____ on _____

_____ _____

Print name of Officer, Partner or Proprietor

Signature of Officer, Partner or Proprietor

_____

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

Horizon

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)

For purposes of certification as a New Jersey Small Employer, an Employer is considered to be a Small Employer if the Employer satisfies **either** of the definitions set forth below. Check which definition applies to the Employer named above.

☐ **(A) Small Employer pursuant to N.J.S.A. 17B:27A-17 modified as required by 26 U.S.C. 4980H**
This definition counts eligible employees. Eligible employee means a full-time employee who works a normal work week of 25 or more hours. Eligible employee excludes sole proprietors, a partner in a partnership, independent contractors, spouses and employees working fewer than 25 hours per week, employees working on a temporary or substitute basis and employees participating in an employee welfare arrangement pursuant to a collective bargaining agreement.

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 an average of at least one, but not more than 50, eligible employees on business days during the preceding Calendar Year, and
- employs at least one eligible employee on the first day of the Plan Year.

Eligible employees and any dependents to be covered must live, work or reside in the service area of the Group Health Plan.

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.

☐ **(B) Small Employer pursuant to 45 C.F.R. 155.20**
This definition counts employees. Employee means an individual who is an employee under the common law standard. Employee excludes a sole proprietor, a partner in a partnership and more than a 2 percent S corporation shareholder as well as immediate family members of such individuals. Employee also excludes a leased employee.

In connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, an employer with a business location in the state of New Jersey who:

- employed an average of at least one but not more than 50 employees on business days during the preceding calendar year; and
- who employs at least one employee on the first day of the Plan Year.

Employees and any dependents to be covered must live, work or reside in the service area of the Group Health Plan.

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 which was not in existence throughout the preceding Calendar Year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such Employer will employ on business days in the current Calendar Year.

The following calculation must be used to determine if an employer employs at least 1 but not more than 50 employees. For purposes of this calculation:

a) Employees working 30 or more hours per week are full-time employees and each full-time Employee counts as 1;

b) Employees working fewer than 30 hours per week are part-time and counted as the sum of the hours each part-time. Employee works per week multiplied by 4 and the product divided by 120 and rounded down to the nearest whole number.
Add the number of full-time Employees to the number that results from the part-time employee calculation. If the sum is at least 1 but not more than 50 the employer employs at least 1 but not more than 50 Employees.

Complete the following sections if the Employer is a Small Employer as defined above in (A) or (B).

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.

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

The following information will be used to calculate the **participation** rate. Refer to the definition of "eligible employee" on page 1.

Total # Eligible Employees _____

Total # Eligible Employees applying/enrolling for health benefits coverage _____

Total # Eligible Employees waiving health benefits coverage under the policy with coverage under their spouse's coverage, other than individual coverage, Medicare, Medicaid, or NJ FamilyCare or Tricare or any other group Health Benefits Plan **through a different employer** _____

Total # Eligible Employees waiving health benefits coverage under the policy with coverage under a Health Benefits Plan **issued by another carrier and offered by the small employer** _____

Please separately list the name(s) of the other carrier(s) and the number of employees covered under each:

_____ _____

_____ _____

Total # Eligible employees waiving health benefits coverage under the policy without coverage under a spouse's or parent's group coverage; Medicare, Medicaid, or NJ FamilyCare or Tricare or any other Health Benefits Plan _____

Total # Employees in an ineligible class or classes _____

The following information will be used to determine how certain federal laws apply to the Small Employer.

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.)

What is the **average** number of employees you employed during the entire **previous calendar year** regardless of whether they were eligible for enrolled for group coverage? _____

(When answering this question please count any employee for whom your company issues a W-2 and include full-time, part-time and seasonal workers.)

CERTIFICATION AS A SMALL EMPLOYER IN THE STATE OF NEW JERSEY

For a Group Health Benefits Plan

Please sign and date appropriate section indicating whether or not you meet the definition of a small employer which is an "either or" definition.

☐ I certify that I qualify as a Small Employer in the State of New Jersey in either. ☐ (A) ☐ (B)

AND

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

☐ I certify that I have obtained and maintain a stand-alone pediatric dental plan for all employees and dependents enrolling for health benefits coverage.

Signature of Officer, Partner or Owner	*Title*	Date
Print Name of Officer, Partner or Proprietor		Date
Signature of Witness		Date

☐ **I certify that I am NOT a Small Employer in the State of New Jersey, as defined in either (A) OR (B) above.**

Signature of Officer, Partner or Proprietor	*Title*	Date
Print Name of Officer, Partner or Proprietor		Date
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 if you have certified that the Employer is a Small Employer using definition (A) or (B)

***CENSUS INFORMATION**

Please include the following persons in the following list:

a. a employees, owners, partners, and officers 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. b employees, owners, partners and officers 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:

O: Owner, partner or officer
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
S: Seasonal employee
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)	Date of Birth
1.						
2.						
3.						
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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 #: _____
Last First MI

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. 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: _____ _____ _____
Last First MI

Carrier: _____ Policy Number: _____

Policyholder/Name: _____ _____ _____
Last First MI

Carrier: _____ Policy Number: _____

Policyholder/Name: _____ _____ _____
Last First MI

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.

_____ Date: _____ / _____ / _____
Signature of Employee MM DD YYYY

_____ Date: _____ / _____ / _____
Signature of Witness MM DD YYYY