Please return to Business Office

Reset Form

Horizon Blue Cross Blue Shield of New Jersey

ENROLLMENT/CHANGE REQUEST

Horizon BCBSNJ Dental Programs

P.O. Box 1710
Newark, NJ 07101-1938
www.HorizonBlue.com/dental
1-800-4DENTAL

Group Information - To Be Completed by Employer

Group Name	Group Number	Subgroup Number

A. Type of Activity - To Be Completed by Employer *Refer to instructions on back before completing this form. Print clearly.*

1. Enrollment
☐ New Subscriber

Effective Date
_______/_______/_______

Date of Hire
_______/_______/_______

2. Change - *Check all that apply.* **Date of Event** **Reason**

☐ Add Spouse
☐ Domestic Partner
☐ Civil Union Partner ___/___/___ ____________
☐ Add Dependent Child ___/___/___ ____________
☐ Name Change ___/___/___ ____________
☐ Change Plan ___/___/___ ____________
☐ Other ___/___/___ ____________
☐ Add/Change Dentist Office ID

3. Remove or Terminate - *Check all that apply.* **Effective Date** **Reason**

☐ Remove Spouse/Domestic Partner/ Civil Union Partner* ____/____/____ ____________
☐ Remove Dependent Child* ____/____/____ ____________
☐ Employee Withdrawal/Termination ____/____/____ ____________

Note: Employee must be enrolled for spouse/domestic partner/civil union partner/ dependent(s) to have coverage.
*Please complete Add/Change/Remove and Name columns in Section D.

4. Continuation of Coverage, i.e., COBRA, State, Total Disability

Not all options are available. Contact Employer for available options.
Coverage For: ☐ Employee ☐ Dependents
Length of Continuation: ☐ 18 mos ☐ 29 mos* ☐ 36 mos ☐ Total Disability

Date of Loss of Coverage: ____/____/____
Date of Qualifying Event: ____/____/____
*Attach proof of disability

B. Employee Information - Complete Sections B - G

Social Security Number	Last Name, First Name, M.I.			Home Telephone ( )
Home Address	Apt. No.	City, State		ZIP Code
Employer Name				Work Telephone ( )
Work Address		City, State		ZIP Code
Date of Employment		Hours Worked		

C. Plan Option - Your selection must be offered by your employer.

Horizon BCBSNJ	Horizon Healthcare Dental	Contract Type
☐ Horizon Dental Option		☐ S - Single ☐ F - Family
☐ *Horizon Dental Choice Plan A		☐ 2 Adults
*Horizon Total Care		☐ P/C - Parent & Child

I wish to waive dental coverage and not enroll in any dental plan

*Please select Dentist Office ID Number-Section D

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. Attach proof if full-time college student. Attach proof of disability.

	(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex M F	Birthdate MM DD YYYY	Social Security Number	Other Dental Coverage Check if Yes	Dentist Office ID Number (if applicable)	NPI Number	Current Patient Check if Yes	Previous Coverage Check if Yes
Employee			☐ ☐	/ /		☐			☐	☐
Spouse			☐ ☐	/ /		☐			☐	☐
Domestic Partner			☐ ☐	/ /		☐			☐	☐
Civil Union Partner			☐ ☐	/ /		☐			☐	☐
Child			☐ ☐	/ /		☐			☐	☐
Child			☐ ☐	/ /		☐			☐	☐
Child			☐ ☐	/ /		☐			☐	☐

E. Other/Previous Insurance

Is your Spouse/Domestic Partner/Civil Union Partner Employed? ☐ Yes ☐ No If "Yes," give name & address of spouse's/ Domestic Partner's/Civil Union Partner's employer.

If "Yes" to Other Dental Coverage (Section D), give name & policy number of insurance carrier, HMO, or other source.

If "Yes" to previous coverage, identify name(s) of persons, give effective date and date coverage terminated, name of previous carrier and plan number and submit a copy of the Certificate of Credible Coverage issued by the previous carrier, if available.

F. Dependent Information

Does any dependent listed in Section D live at a different address than the Employee? ☐ Yes ☐ No If "Yes," who and at what address?

Explain the circumstances.

If any dependent's last name differs from yours, explain the circumstances.

G. Employee Signature

If you have any questions concerning the benefits and services provided by or excluded under this contract, contact a benefits representative at your company before signing this form.

I represent that all the information supplied in this enrollment/change request form is true and complete. I hereby agree to the conditions of enrollment on the reverse side of the employee copy of this enrollment/ change request. I authorize deductions from my earnings for any required contribution.

Employee Signature - *Required*
X

Date / /

E-Mail Address

H. Employer Verification - To Be Completed by Employer

Employer Signature - *Required*
X

Title

Date / /

Employee copy may be used as a temporary ID card for 30 days from the effective date if authorized by employer. Coverage must be verified with Horizon BCBSNJ Dental Programs prior to visiting a specialist or admission to a hospital.

Services and products may be provided by Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare Dental, Inc., each of which is an independent licensee of the Blue Cross and Blue Shield Association. Horizon Healthcare Dental Inc., is a subsidiary of Horizon Blue Cross Blue Shield of New Jersey.

2149 (W0208)

You may complete the required fields below online and then save or print a copy for submission. To save a completed copy to your computer, choose File > Save As to rename the file and save the form with your information to your computer.

NJ-HINT

Instructions

Employer

- Complete the **Employer Group Information** in the upper right corner of the form.
- **Section A - Type of Activity:** Check box(es) indicating reason(s) for submitting The Enrollment Change Request Form.
  If reason is other then indicated check **other** in box 2 and provide reason (i.e., rehire, open enrollment, newly eligible or previously refused/waived coverage).
- Complete **Section H - Employer Verification** in the lower right corner of the form.
  - Employer must complete this section for all new enrollments, coverage changes and terminations.
  - Employer must sign and date The Enrollment/Change Request Form in order for it to be processed.

Employee - Complete Sections B - G

Section B - Employee Information:

Complete **all** information in order for your application to be processed.

Section C - Plan Option:

- Check one Plan Option box, indicate Plan Option Name (where applicable).
- Select only an option offered by your employer.
- Select Contract Type: **S**-Single, **F**-Family, **2**-Adults (Husband/Wife, Domestic Partner or Civil Union Partner), **P/C**-Parent & Child

Section D - Individuals Covered:

- Add/Change/Remove - Use “A”, “C”, or “R” to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
- If a dependent is a full-time college student, you **must** attach a current course schedule or a letter from the school confirming full-time student status (12 or more credits). If dependent is disabled and being continued beyond the limiting age, attach proof of disability.
- If you or your dependent(s) have other dental coverage, check off the “Yes” box(es) and complete Section E - Other/Previous Insurance.
- If the Plan Option selected is Horizon Dental Choice or Horizon TotalCare Dental-from the appropriate Provider directory, locate the alphanumeric office ID code for the dentist. Indicate office ID number selection(s) and NPI Number on the form. Only one provider selection allowed under the Horizon TotalCare Dental Option per family
- If you are a current patient, please check the “Current Patient” box. (only applicable if the Plan Option selected is Horizon Dental Choice or Horizon TotalCare Dental).

Section E - Other/Previous Insurance:

Complete this section for all new enrollments or coverage changes. Coverage includes group, governmental and Medicare coverages and church plans.

Section F - Dependent Information:

Complete this section for all new enrollments or coverage changes. Coverage includes group, governmental and Medicare coverages and church plans.

Section G - Employee Signature:

- Complete this section for all new enrollments, coverage changes and terminations.
- Employee must sign and date the Enrollment/Change Request Form in order for it to be processed.

Section H - Employer Verification:

- Employer must complete this section for all new enrollments, coverage changes and terminations.
- Employer must sign and date the Enrollment/Change Request Form in order for it to be processed.

Conditions of Enrollment

Employee Acknowledgements and Agreements

On behalf of myself and the dependents listed on the reverse side, I agree to or with the following:

1. a) I authorize the sources stated below to give to Horizon BCBSNJ, or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition. Authorized sources are: any physician or medical professional; any hospital, clinic or other medical care institution; any carrier; any consumer reporting agency; any employer.

   b) I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which Horizon BCBSNJ has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.

   c) I know that I have a right to receive a copy of this authorization if I request one.

   d) I agree that a photocopy of this authorization is as valid as the original.

2. I acknowledge by enrolling in a Horizon BCBSNJ dental program, coverage is provided by Horizon BCBSNJ in accordance with the contract.

3. Enrollment of myself and of the listed dependents into the plan is effective on acceptance by Horizon BCBSNJ.

4. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. My employer is hereby authorized to withhold payments from my wages, as appropriate.

Misrepresentation

5. 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.

Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work

DELRAN TWP BOE - 087275 - (DOP /HDC A / TC)

Choice Plan

		Dental Option Plan	HDC Plan A	TotalCare
Annual Deductible		NONE	NONE	NONE
Out-of-network		Yes	No	No
Annual Maximum		$2,000	NONE	NONE
COVERED SERVICES		OUT-OF-POCKET COSTS	OUT-OF-POCKET COSTS	OUT-OF-POCKET COSTS
Exams and Preventive Services+	Eligible exams Fluoride treatment (child) Sealant application Prophylaxis	0%	0%	0%
X-rays+	Panoramic Full-mouth X-rays	0%	0%	0%
Space maintainers*+	Space maintainer – fixed unilateral/bilateral	25%	50%	0%
Restorations and Repairs*+	Amalgam restorations Composite restorations (other than for molars)	25%	0%	0%
Endodontics*+	Pulp cap/Pulpotomy Root canal therapy – anterior, bicuspid	25%	0%	0%
	Root canal therapy – molar	25%	50%	0%
	Denture adjustments and repairs	25%	50%	0%
Periodontics*+	Scaling and root planing Gingivectomy Soft tissue grafts Periodontal maintenance	25%	0%	0%
	Osseous Surgery	25%	50%	0%
Oral Surgery*+	Routine extractions Soft tissue surgical extractions Incision and drainage of abscess	25%	0%	0%
	Surgical extractions – impacted	25%	50%	0%
COVERED SERVICES		OUT-OF-POCKET COSTS	OUT-OF-POCKET COSTS	OUT-OF-POCKET COSTS
Major Restoration*+	Crowns	50%	50%	0%
Dentures*+	Complete and partial dentures	50%	50%	0%
Fixed Bridges*+	Retainers and pontics	50%	50%	0%

* Deductible applies
+ Annual Maximum applies

Services are for illustrative purposes only. For complete listing of covered services, plan limitations, deductibles and maximums, consult your benefit booklet.

Dental Vocabulary

Visits and Exams

Fluoride Treatment - a prescription strength fluoride product that helps strengthen the tooth surface and prevent cavities.

Sealant Application - a composite material used to seal the decay-prone pits, fissures and grooves of children's teeth to prevent tooth decay.

Space Maintainer - a dental appliance that fills the space of a lost tooth or teeth and prevents other teeth from moving into the space. Used especially in orthodontic and pediatric treatment.

Prophylaxis - the scaling and polishing procedure performed to remove calculus, plaque and stains from teeth.

Restorations and Repairs

Restoration - any material or device used to replace tooth structure lost because of decay or fracture.

Amalgam - an alloy used to restore teeth.

Composite Restoration - a tooth-colored material used to restore teeth.

Endodontics

Endodontics - the dental specialty that deals with injuries to or diseases of the pulp, or nerve, of the tooth.

Pulp Cap - procedure used by which pulp is covered with a dressing or cement.

Pulpotomy - to remove a portion of the tooth's pulp.

Root Canal Therapy - the process of treating disease or inflammation of the pulp or root canal. This involves removing the pulp and tooth's nerves and filling the canal(s) with an appropriate material for a permanent seal.

Anterior - refers to the teeth and tissues toward the front of the mouth.

Molar - the broad, multicusped back teeth used for grinding food.

Bicuspid - a two-cusped tooth found between the molar and the cuspid.

Periodontics

Periodontics - the dental specialty that deals with injuries or diseases of the gums and supporting tissues.

Scaling - a procedure used to remove plaque, calculus and stains from the teeth.

Root Planning - the process of scaling and planning root surfaces to remove all calculus, plaque and infected tissue.

Gingivectomy - the surgical removal of gingival (gum) tissue.

Osseous Surgery - *surgery performed to correct damage to gingival (gum) tissue and supporting structures as a result of periodontal disease.*

Oral Surgery

Surgical Extractions - extraction of an unerupted tooth by making a surgical incision.

Incision and Drainage of Abscess - making an incision so the trapped liquids in the infected tissue can escape.

Major Restoration

Crowns - the portion of the tooth that is covered by enamel. Also a dental restoration that covers the area of the tooth and restores it to its original shape.

Dentures

Complete Dentures - a dental prosthesis that replaces all the natural teeth of a single dental arch.

Partial Dentures - a dental prosthesis that replaces one or more, but less than all, of the natural teeth and associated structures in an arch.

Fixed Bridges

Retainers - the part of a fixed bridge that attaches a false tooth to a natural tooth or implant.

Pontics - an artificial tooth used in a fixed bridge to replace a missing tooth.

Products are provided by Horizon Blue Cross Blue Shield of New Jersey, an independent licensee of the Blue Cross and Blue Shield Association. ® Registered marks of the Blue Cross and Blue Shield Association. ®´ and SM Registered and service marks of Horizon Blue Cross Blue Shield of New Jersey. © 2007 Horizon Blue Cross Blue Shield of New Jersey