



Small Employer Reform Product Conversion Application Instructions

Instructions

This form 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 the form in its entirety. Please print in ink or type your responses. One form must be completed for each new product being offered. Ensure that all areas requiring a signature and date are complete.

Documents Included

Attached you will find the paperwork necessary to apply for a Small Employer Reform Product Conversion. In addition to the attached paperwork, if you are requesting:

- ⇒ **An entire group product conversion from a non-managed product** (Horizon Direct Access, Horizon PPO, and indemnity coverage) **to a managed product** (Horizon HMO and Horizon POS) **you must submit an Enrollment/Change Request Form for each employee.**
 - ⇒ To change products for a subset of employees, **you must submit an Enrollment/Change Request Form** to remove the employee from their existing product. In addition, **you must submit another Enrollment Change/Request Form** to add the employee to the new product.
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Changes that must be submitted on group letterhead

The following requested group changes must be submitted separately on group letterhead:

- Mailing or physical address(es)
 - Telephone or fax number(s)
 - E-mail address
 - Group contact name
 - COBRA / TEFRA eligibility
 - Tax identification number
 - Type of organization (corporation, partnership, proprietorship, other)
 - Nature of business
-

Changes that must be submitted on Conversion application

The following group changes can only be submitted on the attached application:

- Waiting period (can only be changed effective on the group's anniversary date)
 - Coverage requested for employees only or employees and dependents
 - Domestic partner election
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Rate Quotes

When submitting your paperwork as required above, you must also submit the appropriate rate quote. The rate quote generated should match the product indicated on the attached Small Employer Reform Product Conversion Application.

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.

Late Paperwork

If you are submitting conversion paperwork 14 calendar days (or less) prior to the group's requested effective date, delivery of your ID cards and system activation may occur after your effective date.

Mailing Instructions

Please send the completed paperwork and necessary attachments to your local sales office.



Horizon Blue Cross Blue Shield of New Jersey

Effective Date: _____

Group Number: _____

Small Employer Reform Product Conversion Application

SECTION I: COMPANY INFORMATION

Company Name: _____

Affiliated Companies: _____

Number of eligible employees: _____ Number of employees to be insured: _____

Note: Other requested group changes must be submitted separately on group letterhead. Please refer to the instruction sheet for examples of other group changes.

SECTION II: SPECIFICATIONS FOR COVERAGE

Medical Product: _____

Deductible: _____

Coinsurance: _____

Coinsurance Charge Limit: _____

Copayment: _____

Hospital Copayment Rider: Yes No

Prescription Drug: _____

Dental: Same Add Not Applicable

Premium Paid: Monthly Quarterly Automatic Checking Withdrawal

One Bill Option: Yes No

Waiting Period: new hire / rehire _____

Classes to be excluded: _____ Number excluded: _____

Insurance Requested For: Employees Only Employees & 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 children of a covered domestic partner? Yes No

SECTION III: SIGNATURE

It is understood that no individual shall become insured while not actively at work on a full-time basis, unless due to health, and only full-time employees are eligible. A full-time employee is one who regularly works at least 25 hours per week at this employer's place of business. It is further understood that no agent has power on behalf of Horizon Blue Cross Blue Shield of New Jersey to make or modify any request or application for insurance or to bind Horizon 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. No contract of insurance is to be implied in any way on the basis of the completion and/or submission of this application.

Any person who knowingly files a statement of claim, application for insurance, enrollment form, or certification containing any false or misleading information may be subject to criminal and civil penalties.

Print name of Officer, Partner, or Owner

Signature of Officer, Partner, or Owner

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	
<input type="checkbox"/> Approved for _____	Number of Subscribers _____
<input type="checkbox"/> Declined	
Band _____	Date _____
Underwritten By _____	Pre-Ex Applies <input type="checkbox"/> Yes <input type="checkbox"/> 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																																	
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