Horizon Blue Cross Blue Shield of New Jersey

Attn: Large and Mid-Size Group Enrollment
Horizon Blue Cross Blue Shield of NJ
PO Box 10168
Newark, NJ 07101-3168
www.HorizonBlue.com

Dependents to Age 30 Enrollment Form

A. Group & Employee Information

Group Name: ______________________ Group #: ______________________

Employee Name: ______________________ Employee ID # ______________________

B. Type of Activity (See Important Explanatory Information on back) Check all that apply

Date of Event **Change:**

___/___/___ ☐ Add dependent over the limiting age, but less than 30

___/___/___ ☐ Remove dependent over the limiting age, but less than 30

Reason(s): ______________________

___/___/___ **Continuation of Coverage pursuant to P.L. 2005, c. 375**

Coverage is being affected:

☐ During an Open Enrollment

☐ Within 30 days after eligibility for other reasons

☐ Within 30 days prior to attainment of limiting age

☐ During special 12-month enrollment

Billing:

☐ Direct bill dependent (add billing address):

____

____

C. Over-age Dependent Information

Name: ______________________
Last First MI

Sex: ☐ M ☐ F Birthdate: ___/___/___ (MM / DD / YY) SS#: ______________________

Other Health Coverage: ☐ Yes ☐ No Other Rx Drug Coverage: ☐ Yes ☐ No

Primary Ofc ID #: ______________________ Ob/Gyn Ofc ID #: ______________________

Current Patient: ☐ Yes ☐ No Current Patient: ☐ Yes ☐ No ☐ N/A

Previous Coverage: ☐ Yes ☐ No If yes, provide the following information **AND** submit a copy of the Certificate of Creditable Coverage that was issued by the previous carrier, if available:

Effective date of prior coverage: ___/___/___ Termination date of prior coverage: ___/___/___

Name of prior carrier: ______________________ Prior plan #: ______________________

D. Signature

______________________ Employee

Date: ___/___/___

______________________ Dependent

Date: ___/___/___

______________________ Employer Name & Title Date: ___/___/___

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