



Horizon Blue Cross Blue Shield of New Jersey

Attn: Please fax form to the following #:
For Small Group: 973-274-2238
For Mid/Large Group: 973-274-4227
Horizon Blue Cross Blue Shield of NJ
P.O. Box 10168
Newark, NJ 07101-3168
www.HorizonBlue.com

Florida Dependent Health Coverage 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 FL.SB 2534

Coverage is being affected:

[] During an Open Enrollment

[] Within 30 days before or after eligibility for other reasons

[] Within 30 days before or after losing coverage due to attainment of limiting age

[] During special enrollment period 6/1/12 - 8/31/12

C. Over-age Dependent Information

Name: _____
Last First MI

Sex: [] M [] F Birthdate: ____/____/____ SS#: _____
MM DD YYYY

Other Health 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 _____

Dependent _____

Date: ____/____/____

Date: ____/____/____

Employer Name & Title _____ Date: ____/____/____

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.

IMPORTANT EXPLANATORY INFORMATION

An adult child may request to continue as a dependent on his or her parent's coverage even after the child reaches the limiting age under the terms of the policy if the adult child:

- Is not yet 30 years old
- Is unmarried
- Has no children
- Is a resident of Florida or, if not a Florida resident, is a full or part-time student at an accredited institution of higher education
- Is not eligible for Medicare and is not actually covered under another group or individual health plan.

An adult child may make request to continue as a dependent on his or her parent's coverage either:

- When he or she first reaches the limiting age
- When he or she first becomes eligible for a reason other than reaching the limiting age (for example, the adult child becomes a full-time or part-time student in another state, or returns to live in Florida after residing elsewhere), or
- During the open enrollment period for the group of which the parent is a member.

Please submit the supplemental enrollment form for large/mid-size groups directly to fax server# 1- 973-274-4227 and for small group to fax server# 1- 973-274-2238.