Horizon Healthcare

Dept A
P.O. Box 607
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GROUP COVERAGE EMPLOYEE ENROLLMENT APPLICATION

For Products:
HORIZON EPO
HORIZON PPO
VISTA
VISTA PLUS

PLEASE PRINT CLEARLY, COMPLETE ALL PERTINENT SECTIONS TO AVOID PROCESSING DELAYS.

SUBSCRIBER INFORMATION

1. EMPLOYEE'S LAST NAME	FIRST	MI	2. PHONE-WORK ( )	3. HOME ( )	4. EMPLOYEE NUMBER	5. CONTRACT TYPE-HEALTH
						☐ Single ☐ Family ☐ Husband/Wife ☐ Parent/Child
6. ADDRESS-STREET	CITY, STATE			ZIP	COUNTY	
7. EMPLOYER NAME AND LOCATION (CITY AND STATE)				8. DATE OF HIRE	9. WORKING STATUS ☐ Active ☐ Retired	PRESCRIPTION ☐ S ☐ F ☐ HW ☐ PC
10. MARITAL STATUS ☐ Single ☐ Widowed ☐ Divorced ☐ Married ☐ Separated				11. PRODUCT ☐ HORIZON EPO ☐ HORIZON PPO ☐ VISTA ☐ VISTA PLUS		DENTAL, IF OFFERED ☐ S ☐ F ☐ HW ☐ PC

ELIGIBLE PERSONS TO BE ENROLLED

12. SELF - LAST NAME	FIRST	MI	13 .RELATION	14. SEX	15. BIRTHDATE	16. SOC. SEC. NO.
			Self	☐ Male ☐ Female		
DEPENDENT #1 - LAST NAME	FIRST	MI	RELATION ☐ Spouse ☐ Child ☐ Other	SEX ☐ Male ☐ Female	BIRTHDATE	SOC. SEC. NO.
DEPENDENT #2 - LAST NAME	FIRST	MI	RELATION ☐ Spouse ☐ Child ☐ Other	SEX ☐ Male ☐ Female	BIRTHDATE	SOC. SEC. NO.
DEPENDENT #3 - LAST NAME	FIRST	MI	RELATION ☐ Spouse ☐ Child ☐ Other	SEX ☐ Male ☐ Female	BIRTHDATE	SOC. SEC. NO.
DEPENDENT #4 - LAST NAME	FIRST	MI	RELATION ☐ Spouse ☐ Child ☐ Other	SEX ☐ Male ☐ Female	BIRTHDATE	SOC. SEC. NO.

17. DO YOU HAVE A DISABLED CHILD DEPENDENT? ☐ YES ☐ NO
IF DEPENDENT IS DISABLED, PLEASE ATTACH MEDICAL DOCUMENTATION (FROM EMPLOYER) TO DETERMINE COVERAGE BEYOND YOUR EMPLOYER'S MAXIMUM DEPENDENT AGE.

COORDINATION OF BENEFITS

YOUR HORIZON HEALTHCARE CONTRACT CONTAINS A COORDINATION OF BENEFITS (C.O.B.) PROVISION. COORDINATION OF BENEFITS IS IN EFFECT WHEN MORE THAN ONE GROUP HEALTHCARE PLAN OR PROGRAM COVERS A PERSON. IF YOU OR ANY FAMILY MEMBER ARE COVERED BY ANOTHER GROUP HEALTHCARE PLAN PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM WHERE APPLICABLE.

SIGNATURE

18. PLEASE READ THE FOLLOWING AND SIGN IN THE SPACE PROVIDED.
I HEREBY APPLY FOR HORIZON HEALTHCARE COVERAGE FOR ME AND MY ELIGIBLE DEPENDENTS WHO ARE LISTED ON THIS APPLICATION. I UNDERSTAND AND AGREE THAT OUR COVERAGE WILL BE CONTROLLED BY THE WRITTEN AGREEMENT BETWEEN HORIZON HEALTHCARE OF NEW YORK AND MY EMPLOYER. I AUTHORIZE MY EMPLOYER TO MAKE DEDUCTIONS FROM MY EARNINGS, IF REQUIRED, FOR MY HORIZON HEALTHCARE COVERAGE. THE UNDERSIGNED HEREBY AUTHORIZE ANY HEALTH CARE FACILITY OR PROVIDER TO RELEASE TO HORIZON HEALTHCARE ALL INFORMATION RELATING TO PAST, PRESENT, AND FUTURE HEALTH CARE EXAMINATIONS OR TREATMENTS RECEIVED BY EACH PERSON COVERED BY THIS APPLICATION. I CERTIFY THAT THE INFORMATION ON THIS APPLICATION IS COMPLETE AND ACCURATE AND THAT EACH PERSON COVERED BY THIS APPLICATION RESIDES WITHIN A HORIZON HEALTHCARE SERVICE AREA. I UNDERSTAND THAT ANY CLAIM BY ME OR ONE OF MY ELIGIBLE DEPENDENTS MAY BE DENIED AND OUR COVERAGE CANCELLED WITHOUT WRITTEN NOTICE IF I HAVE USED MATERIALLY FALSE INFORMATION IN THIS APPLICATION. I ALSO UNDERSTAND THAT SUCH A TERMINATION WILL BE RETROACTIVE TO THE EFFECTIVE DATE OF OUR COVERAGE. IF HORIZON HEALTHCARE ADVANCES PAYMENT TO ANY PROVIDER FOR COVERED SERVICES, I THE UNDERSIGNED WILL RETURN ANY REIMBURSEMENT RECEIVED FOR THESE PREPAID SERVICES TO HORIZON HEALTHCARE.
"ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY, HEALTH MAINTENANCE ORGANIZATION OR OTHER PERSON, FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION."

SIGNATURE OF APPLICANT	DATE	SIGNATURE OF SPOUSE (NOT MANDATORY)	DATE
SIGNATURE OF DEPENDENT AGE 18 OR OVER (NOT MANDATORY)	DATE	SIGNATURE OF DEPENDENT AGE 18 OR OVER (NOT MANDATORY)	DATE

EMPLOYER USE ONLY

REASON FOR APPLICATION	GROUP NUMBER:	EFFECTIVE DATE:	HORIZON HEALTHCARE USE
☐ NEW HIRE ☐ OPEN ENROLLMENT ☐ REHIRE ☐ COBRA ☐ OTHER	EMPLOYER NAME:	EMPLOYER PHONE #:	SALES REP: PROCESSED BY:
	EMPLOYER ADDRESS:		DATE: HMU:
	EMPLOYER SIGNATURE:	DATE:	

ARE YOU: ☐ 1. SINGLE ☐ 2. MARRIED ☐ 3. SEPARATED ☐ 4. DIVORCED

IF YOU CHECKED 1, 2 OR 3 COMPLETE SECTION I.

IF YOU CHECKED 4, COMPLETE SECTIONS I & II.

PLEASE SIGN AND DATE.

IS ANY MEMBER OF YOUR FAMILY COVERED BY ANOTHER GROUP HEALTHCARE PLAN?

☐ YES - IF YES, COMPLETE THE FOLLOWING QUESTIONS.
☐ NO - IF NO, COMPLETE SECTION II IF APPLICABLE.

SECTION I

POLICY HOLDER NAME _____

DEPENDENT'S NAMES _____

EMPLOYER'S NAME _____ ADDRESS _____

NAME OF INSURANCE CO. _____ ADDRESS _____

GROUP / POLICY NUMBER _____ SOCIAL SECURITY NO. _____

EFFECTIVE / CANCEL DATES _____

TYPE OF COVERAGE	☐ SINGLE	☐ FAMILY	☐ PARENT / CHILD	☐ HUSBAND / WIFE
TYPE OF PLAN	☐ POS	☐ PPO	☐ BASIC HOSPITAL	☐ BASIC MED-SURGE
	☐ MAJOR MEDICAL	☐ WRAPAROUND	☐ COMPREHENSIVE	☐ DENTAL

FATHER'S BIRTHDAY _____ MOTHER'S BIRTHDAY _____

POLICY HOLDER NAME _____

DEPENDENT'S NAMES _____

EMPLOYER'S NAME _____ ADDRESS _____

NAME OF INSURANCE CO. _____ ADDRESS _____

GROUP / POLICY NUMBER _____ SOCIAL SECURITY NO. _____

EFFECTIVE / CANCEL DATES _____

TYPE OF COVERAGE	☐ SINGLE	☐ FAMILY	☐ PARENT / CHILD	☐ HUSBAND / WIFE
TYPE OF PLAN	☐ POS	☐ PPO	☐ BASIC HOSPITAL	☐ BASIC MED-SURGE
	☐ MAJOR MEDICAL	☐ WRAPAROUND	☐ COMPREHENSIVE	☐ DENTAL

SECTION II

IS THERE A COURT ORDER REGARDING HEALTH CARE COVERAGE FOR YOUR CHILDREN?

☐ NO COURT ORDER ☐ COURT ORDER FATHER ☐ COURT ORDER MOTHER

WHO HAS CUSTODY? ☐ FATHER ☐ MOTHER ☐ OTHER, SPECIFY _____

HAS THE CUSTODY PARENT REMARRIED? ☐ YES ☐ NO

NAME OF NEW SPOUSE _____

FATHER'S BIRTHDAY _____ MOTHER'S BIRTHDAY _____

LIST THE CHILDREN THAT THE ABOVE INFORMATION APPLIES TO _____

_____

_____

IF ANY EXCEPTIONS, EXPLAIN _____

_____

_____

MEMBER SIGNATURE _____ DATE _____