
HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY ENROLLMENT FORM FOR HORIZON NJ TOTALCARE (HMO D-SNP)

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit [Medicare.gov](https://www.Medicare.gov) to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1.

The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.

What happens next?

Send your completed and signed form to:

Horizon Blue Cross Blue Shield of New Jersey
PO Box 10138
Newark, NJ 07101-9633

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call Horizon Blue Cross Blue Shield of New Jersey at 1-888-328-4542. TTY users can call 711.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Horizon Blue Cross Blue Shield of New Jersey al 1-888-328-4542 (TTY 711) o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-NEW. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

Section 1- All fields on this page are required

Select the plan you want to join: Horizon NJ TotalCare (HMO D-SNP)- \$0 per month

FIRST name: _____ LAST name: _____

Birth date: (MM/DD/YYYY) _____ Sex: Male Female Phone number: _____
(__/__/____)

Permanent Residence street address (Don't enter a PO Box): _____

City: _____ County: _____ State: _____ ZIP Code: _____

Mailing address, if different from your permanent address (PO Box allowed): _____

Street Address: _____
City: _____ State: _____ ZIP Code: _____

Your Medicare information:

Medicare Number: _____

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Horizon NJ TotalCare (HMO D-SNP)? Yes No

Name of other coverage: _____ Member number for this coverage: _____ Group number for this coverage: _____

Are you enrolled in your State Medicaid program? Yes No

If "yes", please provide your Medicaid number: _____

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Horizon NJ TotalCare (HMO D-SNP).
- By joining this Medicare Advantage Plan, I acknowledge that Horizon NJ TotalCare (HMO D-SNP) will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my Horizon NJ TotalCare (HMO D-SNP) coverage begins, I must get all of my medical and prescription drug benefits from Horizon NJ TotalCare (HMO D-SNP). Benefits and services provided by Horizon NJ TotalCare (HMO D-SNP) and contained in my Horizon NJ TotalCare (HMO D-SNP) "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Horizon NJ TotalCare (HMO D-SNP) will pay for benefits or services that are not covered.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
 - 1) This person is authorized under State law to complete this enrollment, and
 - 2) Documentation of this authority is available upon request by Medicare.

Signature: _____ Today's date: _____

If you're the authorized representative, sign above and fill out these fields:

Name: _____ Address: _____

Phone number: _____ Relationship to enrollee: _____

Section 2- All fields on this page are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Select one if you want us to send you information in a language other than English.

Spanish

Select one if you want us to send you information in an accessible format.

Large print

Please contact Horizon NJ TotalCare (HMO D-SNP) at 1-800-543-5656 if you need information in an accessible format other than what's listed above (i.e. Braille or Audio CD). Our office hours are 24 hours a day, 7 days a week. TTY users can call 711.

Do you work? Yes No Does your spouse work? Yes No

List your Primary Care Physician (PCP), clinic, or health center from our Provider Directory at HorizonBlue.com.:

If you do not select a PCP, one will be assigned to you.

A/B/J/K code: _____

E-mail address: _____

By providing your email address, you agree to receive communications from Horizon Blue Cross Blue Shield of New Jersey via email.

Agent Use Only

GA ID: GA Receipt Date: / / NPN#

Name of Broker:

Receipt Date: / / (Selling Agent) Phone #:

Email Address:

Requested Effective Date of Coverage: / / Agent ID:

Opportunity ID: Location ID: Consumer ID:

Event ID:

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- | | |
|--|--|
| <input type="checkbox"/> I am new to Medicare. | <input type="checkbox"/> I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change. |
| <input type="checkbox"/> I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP). | <input type="checkbox"/> I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) _____. |
| <input type="checkbox"/> I recently moved outside of the service area for my current plan, or I recently moved and this plan is a new option for me. I moved on (insert date) _____. | <input type="checkbox"/> I recently left a PACE program on (insert date) _____. |
| <input type="checkbox"/> I recently was released from incarceration. I was released on (insert date) _____. | <input type="checkbox"/> I am leaving employer or union coverage on (insert date) _____. |
| <input type="checkbox"/> I recently returned to the United States after living permanently outside the U.S. I returned to the U.S. on (insert date) _____. | <input type="checkbox"/> I belong to a pharmacy assistance program provided by my state. |
| <input type="checkbox"/> I recently obtained lawful presence status in the United States. I got this status on (insert date) _____. | <input type="checkbox"/> My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan. |
| <input type="checkbox"/> I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____. | <input type="checkbox"/> I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____. |
| <input type="checkbox"/> I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____. | <input type="checkbox"/> I was affected by a weather-related emergency or major disaster (as declared by the Federal Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster. |
| | <input type="checkbox"/> None of these statements apply to me.† |

†If none of these statements applies to you or you're not sure, please contact Horizon Blue Cross Blue Shield of New Jersey at 1-888-328-4542 to see if you are eligible to enroll. We are open Monday through Friday, 8:00 a.m. to 8:00 p.m., Eastern Time. TTY users should call 711.

Horizon NJ TotalCare (HMO D-SNP) is an HMO Medicare Advantage Dual Special Needs plan with a Medicare contract and a contract with the State of New Jersey Medicaid Program. Enrollment in Horizon NJ TotalCare (HMO D-SNP) depends on contract renewal. Products are provided by Horizon NJ Health. Communications are issued by Horizon Blue Cross Blue Shield of New Jersey in its capacity as administrator of programs and provider relations for all its companies. Both are independent licensees of the Blue Cross and Blue Shield Association.

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