RESET

Horizon Blue Cross Blue Shield of New Jersey

AWAY FROM HOME CARE (AFHC) SERVICES APPLICATION

Application Date: _____/_____/_____

A. SUBSCRIBER INFORMATION

Name: _____ Identification #: _____

Address: _____

Home Phone #: _____ Work Phone #: _____

Sex: ☐ Male ☐ Female DOB: _____/_____/_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other

Employer Name: _____ Group #: _____

Type of coverage: ☐ Individual ☐ Family Employment Status: ☐ Active ☐ Retired

B. AFHC MEMBER INFORMATION

Name: _____ SS #: _____

Address away from home: _____

Telephone # away from home: _____

Sex: ☐ Male ☐ Female DOB: _____/_____/_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Dependent

Authorized Representative: _____

Medicare Enrollee: ☐ Yes ☐ No Is Medicare Primary: ☐ Yes ☐ No Medicare ID #: _____

Effective Date: Medicare Part A _____/_____/_____ Medicare Part B _____/_____/_____

Do you have other insurance? ☐ Yes ☐ No

Name of other carrier: _____ Policy #: _____

Email Address for AFHC Member: _____

C. CONTROL INFORMATION

Period of AFHC Membership requested: ☐ New ☐ Renewal

Start Date: _____/_____/_____ End Date: _____/_____/_____

Type of AFHC Membership: ☐ Families Apart ☐ Student ☐ Long Term Traveler (Limited to 6 months)

Validation of AFHC Membership: Please note that Horizon Blue Cross Blue Shield of New Jersey retains the right to request documentation pertaining to your application. Horizon BCBSNJ may request information such as school transcripts or other pertinent information regarding your AFHC membership status to validate the program application.

Renewing AFHC Membership. You must renew your membership for a spouse or dependent 30 days before the AFHC membership period ends or before your group's open enrollment (renewal) date, whichever is sooner.

Notifying us each time you move in or out of the area. Call Member Services each time a AFHC member moves in or out of the New Jersey service area so that we may ensure the AFHC member may receive services and is assigned the proper Primary Care Physician.

If you have questions and need help, call Member Services at the number on the back of your ID card.

D. AWAY FROM HOME CARE AUTHORIZATION

I hereby certify that all information stated in Sections A and B on this application is truthful and correct to the best of my knowledge. I acknowledge that the benefit program providing complimentary coverage to myself or eligible dependents as a AFHC Member of the Host Plan may vary from the benefit program at my Home Plan. Please consult the member welcome kit or other pertinent coverage documents that will be made available to you from the Host Plan. AFHC Membership generally provides coverage for medical, hospital, and behavioral health services but does not provide coverage for prescription drugs or other kinds of services such as dental benefits. Please continue to use your Home Plan benefits for any applicable prescription drug benefits, if available. I understand that as a AFHC Member the Host Plan's benefit program's scope and levels of coverage apply.

_____ _____

Signature of Subscriber Date

"I hereby authorize my Home coverage and my Host coverage, to exchange medical information about me."

_____ _____

Signature of AFHC Member (parent/guardian for minor) Date