



City of Elizabeth – Retiree Dental Enrollment/Change Form

Member Information

- Full Name: _____
 - Date of Birth: ____ / ____ / ____
 - Gender: ☐ M ☐ F
 - Social Security Number: _____
 - Home Address: _____
 - City: _____ State: _____ ZIP: _____
 - Phone Number: _____
 - Email Address: _____
-

Plan Selection

Please select **one** of the following medical plans by checking the appropriate box:

- ☐ Horizon Dental Choice (DHMO) *Requires Primary Dentist (**NJ Only**)
- ☐ Horizon Dental Option (PPO) Dental Expense Plan

Rates

Please select coverage tier by checking the appropriate box:

Horizon Dental Choice (DHMO) *Requires Primary Dentist (**NJ Only**)

- ☐ Single: \$25.59
- ☐ 2 Adults: \$56.63
- ☐ Family: \$87.29
- ☐ P&C: \$56.63

Horizon Dental Option (PPO) Dental Expense Plan

- ☐ Single: \$47.21
- ☐ 2 Adults: \$93.13
- ☐ Family: \$121.38
- ☐ P&C: \$70.20

Coverage Status:

- ☐ New Enrollment
- ☐ Change to Current Coverage

Dependent Enrollment

If you are enrolling or terming dependents, please complete the section below and indicate the action:

Action	Full Name	Date of Birth	Social Security #	Relationship	Gender
☐ Add	_____	____/____/____	_____	_____	☐ M
☐ Term	_____	____/____/____	_____	_____	☐ F
☐ Add	_____	____/____/____	_____	_____	☐ M
☐ Term	_____	____/____/____	_____	_____	☐ F
☐ Add	_____	____/____/____	_____	_____	☐ M
☐ Term	_____	____/____/____	_____	_____	☐ F

Authorization & Signature

I hereby authorize enrollment in the selected Horizon Blue Cross Blue Shield plan. I confirm that the information provided is accurate to the best of my knowledge.

Signature: _____

Date: ____/____/____
