Horizon Blue Cross Blue Shield of New Jersey
P.O. Box 1609
Newark, N.J. 07101-1609

GE 0094 Annual Family Profile and Claim Notice

Send this form once each calendar year to the address above with your first claim of the year. If any information changes, send a new one. If you have questions about claims or need forms, call 1-800-355-BLUE.

Employer name	Employer phone number	Plan Policy Number
Check one ☐ Active employee ☐ Retired employee ☐ Continued individual		

Employee information

Name	Date of birth	Social Security Number		
Address	City	State	ZIP	Home phone number
Do you have another employer? ☐ Yes ☐ No	If "Yes," please give name of other employer	Other employer's phone number		
Are you covered by another group plan? ☐ Yes ☐ No	If "Yes," please give name of carrier	Plan number	Other carrier's phone number	

Spouse information

Name	Date of birth	Social Security Number	
Name and address of spouse's employer			Phone number of spouse's employer
Is spouse covered by another group plan? ☐ Yes ☐ No	If "Yes," please give name of other carrier	Plan number	Other carrier's phone number

Dependent children information

Name	Date of birth	Sex	Social Security No.	Relation to employee	Handicapped
Name	Date of birth / /	☐ Male ☐ Female	Social Security No. – –	Relation to employee	Handicapped ☐ Yes ☐ No
Name	Date of birth / /	☐ Male ☐ Female	Social Security No. – –	Relation to employee	Handicapped ☐ Yes ☐ No
Name	Date of birth / /	☐ Male ☐ Female	Social Security No. – –	Relation to employee	Handicapped ☐ Yes ☐ No
Name	Date of birth / /	☐ Male ☐ Female	Social Security No. – –	Relation to employee	Handicapped ☐ Yes ☐ No

List any additional dependent children on a separate page and attach it to this form.
If any child is over the limiting age and a full-time student, please give the information requested below.

Name	Name of school	Address of school
Name	Name of school	Address of school

If any child is covered by another group plan, please give the information requested below.

Name	Insured person	Name of carrier	Plan number
Name	Insured person	Name of carrier	Plan number

I authorize any physician, insurer, or other organization to release any information regarding the medical history, treatment, or benefits payable for this claim to the plan administrator or its authorized agent for the purpose of determining benefits payable.

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, may be subject to criminal and civil penalties.

Signature of employee ______ Signature of patient if other than minor child ______ Date ______

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