GROUP ENROLLMENT/CHANGE REQUEST

Upon completion this form should be submitted to the EHT Schools Business Office located at the Slaybaugh Primary School Administrative Offices along with the required documentation.

Group Name: EGG HARBOR TOWNSHIP BOARD EDUCATION

This space to be completed by the employer: *Group#0851J5*
Group#08505K

Section A: Employee to complete

- ☐ Single
- ☐ Parent/Child(ren)
- ☐ 2Adults
- ☐ Family

Section B: Employee to complete

- ☐ Direct Access 15 (sub group 05)
- ☐ Direct Access 10 (sub group 00)
- ☐ Direct Access 0 (sub group 35)
- ☐ Direct Access 15/25 (sub group 10)
- ☐ Direct Access POS (sub group 15)
- ☐ Omnia (sub group 20)
- ☐ NJ Educator's Plan

Plan designs and costs are located at the district's website: www.eht.k12.nj.us under employee benefits.

Section C: Employee Information

Employee Name:____
Last *First* *M*

Address: ____
Mailing Address *City,* *State* *Zip Code*

Social Security #: __________________________ Date of Birth: ___________________________

Phone #: ________________________________ *cell or home* Date of Hire: ___________________________

☐ *Male or* ☐ *Female* ☐ *Single* ☐ *Married* ☐ Civil Union ☐ *Domestic Partner* ☐ *Divorced* ☐ *Widowed*

Section D: Spouse/Civil Union/Domestic Partner and Dependent Information

*Spouse/CU/DP Name ____
Last *First* *M*

Social Security #_______________________ Date of Birth: ______________________ Gender M/F ☐

**Child Name ____
Last *First* *M*

Social Security #_______________________ Date of Birth: ______________________ Gender M/F ☐

**Child Name ____
Last *First* *M*

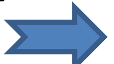
Social Security #_______________________ Date of Birth: ______________________ Gender M/F ☐

**Child Name ____
Last *First* *M*

Social Security #_______________________ Date of Birth: ______________________ Gender M/F ☐

**Child Name ____
Last *First* *M*

Social Security #_______________________ Date of Birth: ______________________ Gender M/F ☐



Section E: Type of Activity-

Enrollment: ☐ New Hire ☐ Return from Leave ☐ Loss of coverage ☐ Other ___________________________

Change: ☐ Add Spouse/Civil Union/Domestic Partner Date of event: ______________________________

Add Dependent: ☐ Birth ☐ Adoption ☐ Loss of coverage Date of event: ______________________________

Change: ☐ Remove Spouse/Civil Union/Domestic Partner Date of Event: _______________________________

☐ Divorce ☐ Term of DP ☐ Dissolution of CU ☐ Death

Address of ex-spouse/ex-partner: ____

(this address will be used to mail the offer of COBRA benefits, as required by law)

Change: ☐ Remove Child SS# _______________________ Reason: ____________________________________

Other Changes: ☐ Name Change Former Name ___________________________________ ☐ Change of Address

☐ Switch Plan From ________________________________ To _____________________________

☐ Other (Not Listed) ____

☐ Terminate Coverage

Instructions:

- *Any time you submit this form it must include each dependent who you wish to remain on your medical insurance. Omission of your spouse or children will result in their removal from the plan.*
- *Please print, except for when a signature is requested*
- *If you are adding a spouse, civil union or domestic partner you must submit a copy of the certificate*
- *If you are enrolling with a spouse you must include a copy of the front page of your most recently filed Federal Tax Form (Form 1040) that includes your spouse. You may black out/white out the financial information (unless you were recently married)*
- *If you are adding a child you must submit a copy of the birth certificate, adoption order or court order of custody or guardianship. Birth certificates must list parent's names. If they do not, you must obtain an updated copy.*
- *If you are removing a spouse/CU/DP you must provide documentation from the court and supply a new address so that the district can offer that person COBRA benefits*
- *If your dependent is disabled and you would like to continue coverage beyond age 26, please contact the office*

I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth by the EHT BOE. I authorize deductions from my earnings for any contributions required from me.

Employee
Signature: ____ Date: _______/_______/_______

The requested activity is believed eligible and is approved by the Employer.

Employer Representative: ____ Date: _______/_______/_______

Representative's Title: ____

Rules:

Benefits Start Date: **a)** 10 month employee beginning work on 9/1, benefits start 9/1 **b)** Begin work on the 1st of the month, start date is in one month **c)** any other situation- using start date, to the 1st of the month plus one month
Benefits Ending Date: **a)** Last paid date, to the 1st of the month plus one month **b)** Last paid date is 1st of month, end date is one month **c)** 10 month employee who worked the entire school will maintain benefits through 9/1 **d)** Death of employee, benefits for spouse/dependents end the 1st of the month following date of death **e)** Divorce- spouse is removed on the 1st of the month following the court date

Enrollment Form

BeneCard PBF
Prescription Benefit Facilitator

TODAY'S DATE:

CLIENT INFORMATION

Egg Harbor Township Board of Education

CLIENT NAME (PLAN SPONSOR / EMPLOYER) | CLIENT # | GROUP #

CARDMEMBER INFORMATION

FIRST NAME | MI | LAST NAME | ID # | SSN#

MAILING ADDRESS | CITY | STATE | ZIP CODE

PHONE NUMBER | CELL PHONE | EMAIL

COVERAGE TYPE

PLEASE CHECK ONE:

☐ SINGLE ☐ CARDMEMBER/SPOUSE ☐ CARDMEMBER/CHILD ☐ CARDMEMBER/CHILDREN ☐ FAMILY

EFFECTIVE DATE:

REASON CODE

A	NEW ENROLLMENT	J	RDS ENROLLMENT, APPLICATION NUMBER IF APPLICABLE: ______________
B	REINSTATE MEMBER	K	ISSUE CARD
C	REINSTATE DEPENDENT / SPOUSE	L	DO NOT ISSUE ID CARD
D	ADD DEPENDENT / SPOUSE	M	COBRA ENROLLMENT
E	TERMINATE COVERAGE	N	COBRA TERMINATION
F	TERMINATE DEPENDENT COVERAGE	O	STUDENT STATUS UPDATE
G	NAME CHANGE	P	DISABLED DEPENDENT
H	ADDRESS CHANGE	Q	OVERAGE DEPENDENT**
I	GROUP CHANGE: FROM__________________ TO __________________	R	DEPENDENT ADDRESS DIFFERS FROM CARDMEMBER (INCLUDE ON BACK)

ELIGIBILITY

	LAST NAME	FIRST NAME	MI	GENDER	BIRTHDATE	SSN	HICN	REASON CODES
CARDMEMBER								
02 SPOUSE								
EMAIL/PHONE*								
03 DEPENDENT								
EMAIL/PHONE*								
04 DEPENDENT								
EMAIL/PHONE*								
05 DEPENDENT								
EMAIL/PHONE*								
06 DEPENDENT								
EMAIL/PHONE*								
07 DEPENDENT								
EMAIL/PHONE*								
08 DEPENDENT								
EMAIL/PHONE*								

*OPTIONAL, ONLY IF DIFFERENT FROM CARMEMBER

COORDINATION OF BENEFITS

SECONDARY COVERAGE ID NUMBER | INSURANCE COMPANY | POLICY / GROUP#

EMPLOYER/PLAN SPONSOR | EFFECTIVE DATE

SIGNATURES

MEMBER SIGNATURE | CLIENT SIGNATURE

FOR INTERNAL USE ONLY:
DATE ENTERED:__________ ENTERED BY:___________ LOGGED BY:___________

Dependent Address (1)
(if differs from cardmember)

Back of Enrollment Form

FIRST NAME MI LAST NAME ID # SSN

MAILING ADDRESS CITY STATE ZIP CODE

PHONE NUMBER CELL PHONE EMAIL

Dependent Address (2)
(if differs from cardmember)

FIRST NAME MI LAST NAME ID # SSN

MAILING ADDRESS CITY STATE ZIP CODE

PHONE NUMBER CELL PHONE EMAIL

Dependent Address (3)
(if differs from cardmember)

FIRST NAME MI LAST NAME ID # SSN

MAILING ADDRESS CITY STATE ZIP CODE

PHONE NUMBER CELL PHONE EMAIL

Dependent Address (4)
(if differs from cardmember)

FIRST NAME MI LAST NAME ID # SSN

MAILING ADDRESS CITY STATE ZIP CODE

PHONE NUMBER CELL PHONE EMAIL

Dependent Address (5)
(if differs from cardmember)

FIRST NAME MI LAST NAME ID # SSN

MAILING ADDRESS CITY STATE ZIP CODE

PHONE NUMBER CELL PHONE EMAIL

Delta Dental

Delta Dental of New Jersey
P.O. Box 23700, Newark, NJ 07189-0001
(973) 285-4144

Dental Enrollment/Change Form

Egg Harbor Township Board of Education	Effective date of Coverage	Delta Dental Premier Plan Group #7131-0105

General Information- This section must be completed- Please print clearly

Name (Last, First, MI)	Date of Birth	Social Security Number

Address (number, street, city, state, zip code)

Date of Employment	____ Single ____ Parent/child ____ Husband/wife ____ Parent/children ____ Family	___ Single ___ Married ___ Divorced	Home Telephone Number

	Name (First, MI, Last)	A-add R-remove C-change	Date of Birth	Social Security Number
Employee				
Spouse				
Dependent				
Dependent				
Dependent				
Dependent				
Dependent				

I understand that any changes to my dependent status must be reported to my employer. I understand that children are covered until the end of the year in which they turn 23 years of age, provided they are dependent upon me for maintenance and support, are not married and do not have coverage of their own. If a dependent is a step-child or legal ward, I understand that I must complete an *Affidavit of Dependency* as available in my employer's human resource office. I hereby represent that all information furnished is true and complete to the best of my knowledge and authorize my employer to make any required deduction from my wages.

Employee Signature ______________________ Date ______________

Egg Harbor Township Board of Education

Benefits Office
13 Swift Drive
Egg Harbor Township, NJ 08234
609-646-7911 x1023
halkam@eht.k12.nj.us

Adding a Dependent

Horizon Enrollment Form
Complete section A and B indicating your plan and your level of coverage
Complete section C with your new information
Complete section D by **listing each dependent who is to be covered on your benefits**
Complete section E by choosing Add Dependent

If you have more than four children to add, please use a second copy of this page.

Please sign

Include the birth certificate, which must include parents' names, of child being added.

Benecard
Complete Cardmember Information
Complete Coverage Type
Complete Eligibility with Each Dependent to be covered. Use Reason Code D for the dependent to be added.
Please sign

Delta Dental
Complete General Information
List each Dependent to be covered. Use Reason Code A for the dependent to be added.
Please sign

Marriage

Horizon Enrollment Form
Complete section A and B indicating your coverage and your level of coverage
Complete section C with your new information
Complete section D by **listing each dependent who is to be covered on your benefits**
Section E: Add your spouse
Please sign

A copy of your most recently filed federal 1040 form is required (you can black out or white out any financials).
A copy of your marriage certificate is required.
If you added any children 26 or under, you must provide a copy of each child's birth certificate.

If you have more than four children to add, please use a second copy of this page.

Egg Harbor Township Board of Education

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Benecard
Complete Cardmember Information
Complete Coverage Type
Complete Eligibility with Each Dependent to be covered. Use Reason Code D for the dependent to be added.
Please sign

Delta Dental
Complete General Information
List each Dependent to be covered. Use Reason Code A for the dependents to be added.
Please sign

Remove Dependent
Horizon Enrollment Form
Complete section A and B indicating your coverage and your level of coverage
Complete section C with your new information
Complete section D by **listing each dependent who is to be covered on your benefits**
Complete section E by listing the dependent you would like to remove
Please sign

Benecard
Complete Cardmember Information
Complete Coverage Type
Complete Eligibility with Each Dependent to be covered. Use Reason Code F for the dependent to be removed.
Please sign

Delta Dental
Complete General Information
List each Dependent. Use Reason Code R for the dependents to be removed
Please sign