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)

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) _____

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 your 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