SCHOOLS HEALTH INSURANCE FUND

Please return the Board Office

Benefits Enrollment Form

Employer Name: **Delsea Regional BOE**

EMPLOYEE/PARTICIPANT INFORMATION (Employee or Dep. 31)

Please **PRINT** and fill this section out **COMPLETELY**

Social Security #:	Last Name:	First Name:	M.I.:
Gender: ☐ Male ☐ Female	Date of Birth:	Address:	
City:	State:	Zip:	Home Phone #:	Work Phone #:
E-mail:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed		
Requested Effective Date:			

DEPENDENT INFORMATION (Spouse, Child or Children)

Please **PRINT** and fill this section out **COMPLETELY**

Please list all eligible dependents only.

Spouse

Social Security #:	First Name:	Last Name:	M.I.:
Date of Birth:	Gender: ☐ Male ☐ Female		

Child(ren)

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female		
Relationship:			

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female		
Relationship:			

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female		
Relationship:			

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female		
Relationship:			

PLAN SELECTIONS

Medical and Prescription

Please select one plan:

Amerihealth Plans

☐ NJ Educators Health Plan w/ Rx $5/$10

☐ EPO $15/$25 w/ Rx $10/$20/$35

☐ PPO $15/$25 w/ Rx $10/$20/$35

Garden State Plan w/ Rx $5/$10

Horizon Plan

☐ Horizon Omnia w/ Rx $10/$20/$35

Aetna Plans

☐ NJ Educators Health Plan w/ Rx $5/$10

☐ Patriot V $5 w/ Rx $10/$20/$35

☐ Patriot X $10 w/ Rx $10/$20/$35

☐ HDHP w/ H.S.A & 20% Rx Coinsurance

☐ Core $25 w/ $15/$35/$50

☐ Buy Up w/ Rx $15/$35/$50

Garden State Plan w/ Rx $5/$10

Type of Coverage: ☐ Single ☐ Family ☐ Husband/Wife ☐ Parent/Child(ren)

☐ I wish to waive medical and prescription coverage ☐ I wish to cancel my medical and prescription coverage

☐ Not eligible for prescription coverage

TYPE OF ACTIVITY

☐ New Hire Date: _____ ☐ Open Enrollment Date: _____ ☐ Address or Name Change Date: _____

☐ Termination of Employment Date: _____ ☐ Termination due to Retirement Date: _____

Addition of Dependent (legal documentation required)

☐ Marriage ☐ Civil Union ☐ Birth ☐ Adoption/Guardianship/Foster Care Date of Event: _____

Add Coverage: ☐ Medical ☐ Prescription

Deletion of Dependent **Date of Event:** _____ **Dependent Name:** _____

☐ Divorce (legal documentation required) ☐ Death of spouse or child ☐ Child over age limit/ineligible

Remove Coverage: ☐ Medical ☐ Prescription

Other

☐ Dependent Age 31 ☐ Newly Eligible (PT or FT)

☐ Death (Name of Deceased): _____ Date of Death: _____

☐ Other (Give Reason):

EMPLOYEE CERTIFICATION

I certify that all of the information supplied on this form is true to the best of my knowledge. I understand if I waive my right to coverage at this time, enrollment is not permissible until the next scheduled open enrollment. I understand that there is no guarantee of continuous participation by medical service providers, doctors or facilities in the Plans. If either my physician or medical center terminates participation in the Plan, I must select another doctor or medical center participating in the same plan. I authorize any hospital, physician or health care provider to furnish my medical plan or its assignee with such medical information about myself or my covered dependents as the medical plans or assignee may require. I also attest that the dependents listed here (if applicable) meet the dependent eligibility criteria of the Plan. I understand that in the event I cover any dependent that does not meet the eligibility provisions of the Plan that doing so shall invalidate their coverage and potentially my coverage and that I may be subject to penalties. I further agree that the SHIF may, at any time, request that I supply evidence that substantiates the eligibility status of any person I cover as a dependent under the Plan.

Print Name: _____ Employee Signature: _____Date:_____