Southern New Jersey Regional Employee Benefits Fund

c/o PERMA, Po Box 99106, Camden, NJ 08101

Client Name: Riverside Township

Employee/Participant Information

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

ENROLLMENT FORM

Social Security #:	Last Name:			First Name:	M.I.:
Gender: ☐ Male ☐ Female	Date of Birth:		Address:		
City:	State:	Zip:	Home Phone #:	Work Phone #:	
E-mail:		PCP # (if required):	Division (if any):		
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed					

Dependent Information (Spouse, Child or Children)

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

Please list all <u>eligible</u> dependents only.

Spouse

Social Security #:	First Name:	Last Name:	M.I.:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	

Child(ren)

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	
Full-Time Student? ☐ Yes ☐ No			

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	
Full-Time Student? ☐ Yes ☐ No			

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	
Full-Time Student? ☐ Yes ☐ No			

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	
Full-Time Student? ☐ Yes ☐ No			

Action to be Taken:

☐ New Enrollment – Effective Date: ________________

☐ Enrollment Change – Effective Date: ________________

Benefit Elections

Medical Coverage & Prescription

☐ **Aetna Choice POS II $10 w/ $3/$10/$10 prescription drug**

☐ **Aetna Choice POS II $15 w/ $3/$10/$10 prescription drug**

☐ **Aetna HMO $10 w/ $3/$10/$10 prescription drug**

Type of Coverage: ☐ EE Only ☐ EE + Child(ren) ☐ EE + Spouse ☐ EE + Family

☐ I elect not to enroll in any medical plan ☐ I wish to cancel my medical coverage

Dental

Carrier Name: Delta Dental PPO/Premier/Advantage

Type of Coverage: ☐ EE Only ☐ EE + Child(ren) ☐ EE + Spouse ☐ EE + Family

☐ I wish to cancel my dental coverage ☐ I elect not to enroll in any dental plan

Type of Activity

☐ **Open Enrollment** **Date:** _____ ☐ **New Hire** **Date:** _____ ☐ **Termination** **Date:** _____

Addition of Dependent

☐ Marriage ☐ Civil Union ☐ Birth ☐ Adoption/Guardianship/Foster Care ☐ Dep 31

Add Coverage: ☐ Medical ☐ Rx ☐ Dental

Deletion of Dependent

☐ Divorce ☐ Death of spouse or child ☐ Child over age limit/ineligible

Remove Coverage: ☐ Medical ☐ Rx ☐ Dental

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.

Print Name: _____ Retiree Signature: _____

Date: _____