

# Southern New Jersey Regional Employee Benefits Fund

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

RETIREE Client Name: **Mt. Laurel Township**

## Employee/Participant Information

Please PRINT and fill this section out COMPLETELY

## ENROLLMENT FORM

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

## 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: <input type="checkbox"/> Male <input type="checkbox"/> Female	PCP # (if required):	

### Child(ren)

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	PCP # (if required):	
Full-Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	PCP # (if required):	
Full-Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	PCP # (if required):	
Full-Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	PCP # (if required):	
Full-Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No			

### Action to be Taken:

New Enrollment – Effective Date: \_\_\_\_\_

Enrollment Change – Effective Date: \_\_\_\_\_

## Benefit Elections

### Medical Coverage & Prescription

Aetna Choice POS II \$10 with Prescription Drug \$10/\$22/\$44

Aetna HMO with Prescription Drug \$6/\$12/\$24

Aetna Choice POS II \$15 with Prescription Drug \$10/\$22/\$44

Aetna HMO \$20 with Prescription Drug \$3/\$18/\$46

Aetna Choice POS II \$15/\$25 with Prescription Drug \$7/\$16/\$35

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

#### Dental PPO Plus Premier

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: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_