COMPANY NAME: Piscataway Township and Board of Education **GROUP #:** 16840

BENEFIT ENROLLMENT FORM

MERITAIN® HEALTH
An Aetna Company

THIS FORM IS TO BE COMPLETED FOR NEW ENROLLMENTS AND COVERAGE CHANGES

PLEASE PRINT CLEARLY AND COMPLETE THE ENTIRE FORM
(ALL INFORMATION MUST BE COMPLETED OR ENROLLMENT WILL BE DELAYED)

EMPLOYEE INFORMATION – ALL INFORMATION IS REQUIRED

LAST NAME	FIRST NAME	MI

SOCIAL SECURITY NO.	DATE OF BIRTH (MM/DD/YY)	GENDER ☐ M ☐ F	MARITAL STATUS ☐ Single ☐ Married ☐ Divorced ☐ Widowed

MAILING ADDRESS	CITY	STATE	ZIP

EMAIL ADDRESS

PRIMARY PHONE NUMBER	PHONE TYPE ☐ HOME ☐ CELL ☐ WORK

ARE YOU THE **EMPLOYEE** COVERED UNDER **ANY** OTHER INSURANCE? ☐YES ☐NO (i.e. Medicare, Tricare, spouse's plan)

IF YES, NAME OF INSURANCE: _____ EFFECTIVE DATE: _____

TYPE OF POLICY (Retiree, COBRA, Spouse): _____ POLICY HOLDER (Self, Spouse): _____

IF ENROLLED IN MEDICARE: EFFECTIVE DATE: PART A _____ PART B _____ MEDICARE ID _____

ENTITLEMENT TO MEDICARE DUE TO: ☐ AGE ☐ DISABILITY ☐ END STAGE RENAL DISEASE (ESRD)

EMPLOYER USE ONLY

DATE OF HIRE	EFFECTIVE DATE

DIVISION #	DEPT. # / CLOCK #

ANNUAL SALARY: $

☐ HOURLY ☐ SALARY

☐ NEW ENROLLMENT
- ☐ Active ☐ Retiree
- ☐ Full Time ☐ Part Time
- ☐ COBRA

☐ ENROLLMENT CHANGE
- ☐ Marriage ☐ Birth ☐ Adoption
- ☐ Reinstatement ☐ Loss of Coverage
- ☐ Other: _____

Employer Representative Signature: _____

Date: _____

BENEFIT SELECTION

COVERAGE TYPE	PLAN ELECTED (IF APPLICABLE)	COVERAGE LEVEL
☐ MEDICAL*		☐ SINGLE ☐ EMPLOYEE + SPOUSE ☐ EMPLOYEE + CHILD ☐ FAMILY ☐ DECLINE
☐ PRESCRIPTION*		☐ SINGLE ☐ EMPLOYEE + SPOUSE ☐ EMPLOYEE + CHILD ☐ FAMILY ☐ DECLINE
☐ VISION		☐ SINGLE ☐ EMPLOYEE + SPOUSE ☐ EMPLOYEE + CHILD ☐ FAMILY ☐ DECLINE

***NJ EHP/GSP require both Medical and Rx coverage to match (i.e. NJ EHP Medical and NJ EHP Rx must be selected)**

DEPENDENT INFORMATION

(ALL INFORMATION MUST BE COMPLETED OR ENROLLMENT WILL BE DELAYED. PROVIDE THE CONTACT INFORMATION FOR ALL ADULT DEPENDENTS AGE 18 AND OVER.)

Special Enrollment due to coverage under Medicaid or under a State Children's Health Insurance Program (CHIP). If an employee or eligible dependent did not enroll in the plan when initially eligible, he or she will be permitted to later enroll in the plan under one of the following circumstances:

a. The employee or eligible dependent loses their eligibility status to participate in Medicaid or CHIP; or

b. The employee or eligible dependent qualifies for premium assistance under Medicaid or CHIP at the state level in which the individual resides.

The employee or eligible dependent must request enrollment in the plan within 60 days after coverage under Medicaid or CHIP terminates or within 60 days of being notified of eligibility for premium assistance from the state in which the individual resides.

DEPENDENT 1 FULL NAME (REQUIRED) LAST, FIRST, MIDDLE			SOCIAL SECURITY NO (REQUIRED)		RELATIONSHIP (REQUIRED)	CHECK COVERAGE
DATE OF BIRTH (MM/DD/YY)	GENDER ☐ M ☐ F	PHONE NUMBER	☐ HOME ☐ CELL ☐ WORK	EMAIL ADDRESS		☐MEDICAL/RX ☐PRESCRIPTION ☐VISION
DEPENDENT 2 FULL NAME (REQUIRED) LAST, FIRST, MIDDLE			SOCIAL SECURITY NO (REQUIRED)		RELATIONSHIP (REQUIRED)	CHECK COVERAGE
DATE OF BIRTH (MM/DD/YY)	GENDER ☐ M ☐ F	PHONE NUMBER	☐ HOME ☐ CELL ☐ WORK	EMAIL ADDRESS		☐MEDICAL/RX ☐PRESCRIPTION ☐VISION
DEPENDENT 3 FULL NAME (REQUIRED) LAST, FIRST, MIDDLE			SOCIAL SECURITY NO (REQUIRED)		RELATIONSHIP (REQUIRED)	CHECK COVERAGE
DATE OF BIRTH (MM/DD/YY)	GENDER ☐ M ☐ F	PHONE NUMBER	☐ HOME ☐ CELL ☐ WORK	EMAIL ADDRESS		☐MEDICAL/RX ☐PRESCRIPTION ☐VISION
DEPENDENT 4 FULL NAME (REQUIRED) LAST, FIRST, MIDDLE			SOCIAL SECURITY NO (REQUIRED)		RELATIONSHIP (REQUIRED)	CHECK COVERAGE
DATE OF BIRTH (MM/DD/YY)	GENDER ☐ M ☐ F	PHONE NUMBER	☐ HOME ☐ CELL ☐ WORK	EMAIL ADDRESS		☐MEDICAL/RX ☐PRESCRIPTION ☐VISION
DEPENDENT 5 FULL NAME (REQUIRED) LAST, FIRST, MIDDLE			SOCIAL SECURITY NO (REQUIRED)		RELATIONSHIP (REQUIRED)	CHECK COVERAGE
DATE OF BIRTH (MM/DD/YY)	GENDER ☐ M ☐ F	PHONE NUMBER	☐ HOME ☐ CELL ☐ WORK	EMAIL ADDRESS		☐MEDICAL/RX ☐PRESCRIPTION ☐VISION

*IF ANY OF THE DEPENDENTS LISTED ABOVE HAVE A MAILING ADDRESS THAT DIFFERS FROM THE EMPLOYEE, PLEASE COMPLETE THE INFORMATION BELOW:

DEPENDENT	MAILING ADDRESS	CITY	STATE	ZIP

*IF YOUR CHILD IS MENTALLY OR PHYSICALLY DISABLED, PLEASE PROVIDE APPROPRIATE DOCUMENTATION. LIST THE NAME(S) OF ANY DISABLED DEPENDENTS:

DEPENDENT	DEPENDENT	DEPENDENT

COMPANY NAME: **Piscataway Township and Board of Education**

COORDINATION OF BENEFITS – SPOUSE INFORMATION (IF APPLICABLE) COMPLETE **ALL** QUESTIONS

IS YOUR SPOUSE EMPLOYED? ☐YES ☐NO IF **YES**, ☐FULL TIME ☐PART TIME SPOUSE EMPLOYER NAME: SPOUSE DATE OF BIRTH:

INDICATE THE COVERAGE, CARRIER NAME AND EFFECTIVE DATE THAT YOUR SPOUSE IS **ENROLLED** IN WITH HIS/HER EMPLOYER

TYPE OF OTHER COVERAGE	CARRIER NAME	CARRIER ADDRESS	EFFECTIVE DATE (MM/DD/YY)	TYPE OF POLICY (I.E. EMPLOYER, RETIREE, COBRA)	LIST ALL FAMILY MEMBERS ENROLLED IN THIS PLAN
☐MEDICAL					
☐PRESCRIPTION					
☐DENTAL					
☐VISION					

COORDINATION OF BENEFITS – DEPENDENT CHILD(REN) INFORMATION (IF APPLICABLE) COMPLETE **ALL** QUESTIONS

ARE ANY OF YOUR DEPENDENT CHILD(REN) COVERED BY ANOTHER PARENT/GUARDIAN OR PLAN NOT LISTED ABOVE? ☐YES ☐NO
EMPLOYER PROVIDING COVERAGE:
IF **YES**, COMPLETE THE QUESTIONS BELOW

TYPE OF OTHER COVERAGE	CARRIER NAME	CARRIER ADDRESS	EFFECTIVE DATE (MM/DD/YY)	TYPE OF POLICY (I.E. EMPLOYER, RETIREE, COBRA)	COURT ORDER REQUIRING COVERAGE (I.E. DIVORCE DECREE, QMCSO)*	LIST ALL FAMILY MEMBERS ENROLLED IN THIS PLAN
☐MEDICAL						
☐PRESCRIPTION						
☐DENTAL						
☐VISION						

***COPY OF THE COURT ORDER MUST BE SUBMITTED. FAILURE TO DO SO WILL RESULT IN CLAIMS BEING DENIED.**

COORDINATION OF BENEFITS – GOVERNMENTAL INSURANCE (I.E. MEDICARE, MEDICAID,TRICARE, ETC.)

IS YOUR SPOUSE AND/OR ARE ANY DEPENDENTS ENROLLED IN ANY GOVERNMENTAL INSURANCE? ☐YES ☐NO IF **YES**, PLEASE COMPLETE BELOW

LIST ALL FAMILY MEMBERS ENROLLED	TYPE OF COVERAGE	EFFECTIVE DATE OR IF MEDICARE COVERAGE, PART A EFFECTIVE DATE	PART B EFFECTIVE DATE (IF APPLICABLE)	MEDICARE ID NUMBER	IS MEDICARE COVERAGE DUE TO:
					☐AGE ☐DISABILITY ☐ESRD
					☐AGE ☐DISABILITY ☐ESRD

PLAN DECLARATION

I understand that the above elections will remain in effect until the last day of the Plan Year for which they are effective and will continue in effect indefinitely beyond that Plan Year unless I make an election change permitted under the Plan. I understand that I may change my elections during the Plan Year only if (i) I experience a "status change", as defined under the Plan, and if my change in elections is consistent with that "status change", (ii) I exercise a Special Enrollment Period Right (as described in the Notice of Special Enrollment Periods below), or (iii) I qualify (under applicable law, as determined by the Plan Administrator) to make another election change because of certain changes in cost or coverage of a benefit option, or for certain other reasons. I understand that the cost of a benefit option that I have elected under the Plan may change from one Plan Year to the next and I hereby agree that my payroll deductions will automatically change accordingly unless I submit a new Election Form during the appropriate annual election period to change or terminate that coverage. I also understand, during a Plan Year, if there is a change in the cost of a benefit option that I have elected, the Employer may automatically increase the payroll deductions, if any, I am required to make per pay period to pay for that benefit option. I understand further that, except to the extent that I am permitted to make a change under the Plan, the payroll deduction elections I have made above will continue in effect notwithstanding any changes in the features or coverage offered under the benefit options I have elected above.

I understand that my employer may modify my benefit elections if appropriate to insure that the Plan complies with the terms of the Plan and the requirements (including tax-qualification requirements) of applicable law and that, subject to the requirements of applicable law or any applicable insurance contract, my employer retains the right to amend or terminate coverage under a benefit option. Also, I understand that the employer may modify my elections for health benefit options if required to do so by a Qualified Medical Child Support Order that requires me to provide health coverage for a dependent.

NOTICE OF SPECIAL ENROLLMENT PERIODS

If you are declining enrollment in the Plan's health coverage options for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Plan's health coverage features if you or your dependents lose eligibility for that coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact your Human Resources representative.

SIGNATURE AND AUTHORIZATION

EMPLOYEE SIGNATURE	PRINT EMPLOYEE NAME	DATE