



**Affirmative Election Form**  
**Effective January 1, 2021**

**EMPLOYEE PARTICIPANT INFORMATION**

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

SSN / DOB:	First Name:	Last Name:	M.I.:
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**Select one option only**

\_\_\_\_\_ I want to keep my **CURRENT PLAN** for plan year effective 1/1/2021. I also understand that I am not able to make any changes to my plan or plan section until the next open enrollment period unless I have a qualifying event.

\_\_\_\_\_ I want to enroll in the **NJ EDUCATORS HEALTH PLAN** effective 1/1/2021. I understand this will mean a change to my Medical and Prescription benefits. I will fill out a new medical and prescription enrollment form and return to the Business Office.

\_\_\_\_\_ I want to continue to **WAIVE** coverage.

*If you experience a qualifying life event and need to make a change in your coverage, please contact the Human Resources Department, within 30 days of the event. Examples of a qualifying event are the following:*

- *Marriage*
- *Loss or reduction of coverage for you or your spouse*
- *Birth or Adoption of a child*
- *Divorce*
- *Death of a covered dependent*

**Employee Signature**

Employee  
Signature:

Date:

**This Section for Employer Use Only**

Approved by:

Date:

Before submitting to HR, please keep a copy for your own personal records.

Once received, processed and approved by the Human Resources Department, a signed copy will be returned to you.