Southern New Jersey Health Insurance Fund c/o PERMA, Park 80 West, Plaza One, Saddle Brook, New Jersey 07663

☐ Check the box if Dependent to Age 31

1. EMPLOYEE INFORMATION - This section must be filled out completely. (Please print or type.)

Social Security Number ___-__-____

Division (if any) _____

Last Name _____ Title (Jr., Sr., etc.) _____

First Name _____ MI _____

A.

Sex (M/F) _____ Date of Birth Mo Day Year _____ Marital Status Single Mar. Div. Widowed

Mailing Address _____ New Address ☐

City _____ State _____

Zip Code +4 _____ Home Telephone number (inc. Area Code) _____

CHANGE DUE TO MEDICARE STATUS? ☐

Attach Copy of Medicare Card

	No	Yes because of age	Yes because of disability
Are you Medicare eligible?	☐	☐	☐
Is your spouse Medicare eligible?	☐	☐	☐

2. MEDICAL COVERAGE

☐ I wish to enroll

Carrier Name _____

Plan Name/Copay ☐ $2 QPOS ☐ $5 QPOS ☐ $10 QPOS

Carrier Code # _____

☐ I wish to change plans

☐ I elect not to enroll in any medical plan

☐ I wish to cancel my medical coverage

TYPE OF COVERAGE

☐ Single ☐ Family ☐ Husband/Wife ☐ Parent/Child(ren)

3. DENTAL COVERAGE

☐ I wish to enroll

Plan Name ☐ Premier ☐ Flagship Complete ☐ NJ6

Carrier Code # _____

☐ I wish to change plans

☐ I elect not to enroll in any dental plan

☐ I wish to cancel my dental coverage

DENTAL ID#

A. _____ D. _____

B. _____ E. _____

C. _____ F. _____

TYPE OF COVERAGE

☐ Single ☐ Family ☐ Husband/Wife ☐ Parent/Child(ren)

EMPLOYER SECTION *To be Completed by Employer*

Employer Name: _____

Action To Be Taken

☐ New Enrollment - Effective Date: _____

☐ Enrollment Change - Effective Date: _____

☐ Return from Leave of Absence - Effective Date: _____

Signature of Certifying Officer _____

Telephone # _____ Date Mailed _____

4. PRESCRIPTION DRUG

☐ I wish to enroll

Plan Name _____

Carrier Code # _____

☐ I wish to change plans

☐ I elect not to enroll in any Rx plan

☐ I wish to cancel my Rx coverage

TYPE OF COVERAGE

☐ Single ☐ Husband/Wife

☐ Family ☐ Parent/Child(ren)

MEDICAL PRIMARY CARE PHYSICIAN ID # (indicate for each family member)

A. _____

B. _____

C. _____

D. _____

E. _____

F. _____

6. DEPENDENT INFORMATION - List eligible dependents only. If dependent is a full-time student under the terms of the Plan, or is disabled, please attach documentation of student status or disability to determine coverage beyond the Plan's maximum dependent age. Provide copy of court order or proof of residency for stepchildren or foster children.

	Last Name	First Name	MI	Date of Birth (Mo/Day/Yr)	M/F	Social Security Number	Natural (C) Adopted (A) Foster (F) Step (S)
SPOUSE B.							
CHILDREN C.							
D.							
E.							
F.							

7. TYPE OF ACTIVITY (check the appropriate box)

7a. ☐ **NEW HIRE** Date _____

7b. ☐ **OPEN ENROLLMENT** Date _____

7c. ☐ **REHIRE** Date _____

7d. ☐ **TERMINATION OF EMPLOYMENT** Date _____

7e. ☐ **COBRA** Please check box indicating reason for COBRA Eligibility

☐ Employment Terminated

☐ Reduction in hours

☐ Spouse/dependent child of deceased employee

☐ Divorce

☐ Loss of dependent child status under plan rules

☐ Spouse/dependent's loss of coverage due to employees Medicare entitlement

7f. **RETIREMENT** Date of retirement _____

☐ Retaining coverage with the Fund

☐ Town Paid Benefits

☐ Medical ☐ Dental ☐ Rx ☐ Vision

☐ Direct Bill Retiree

☐ Medical ☐ Dental ☐ Rx ☐ Vision

7g. **ADDITION OF DEPENDENT** (legal documentation required)

☐ Marriage ☐ Civil Union

☐ Birth ☐ Adoption/Guardianship/Foster care

Date of Event _____

☐ Medical ☐ Dental ☐ Rx ☐ Vision

7h. **DELETION OF DEPENDENT**

☐ Divorce (legal documentation required)

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

Date of Event _____

Dependent Name _____

☐ Medical ☐ Dental ☐ Rx ☐ Vision

7i. **OTHER CHANGES**

☐ NEWLY ELIGIBLE (PT to FT)

☐ DEATH

Name of deceased _____

Date of death _____

☐ OTHER

Give Reason _____

8. **OTHER GROUP HEALTH** ☐ No ☐ Yes

If yes, please attach a copy of the front & back of the ID card for that coverage. Please indicate the name & address of the other carrier.

_____

_____

_____

9. 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.

White, Canary - PERMA Pink - Employer Gold - Employee

Employee Signature _____ Date _____

ENROLLMENT/CHANGE FORM