



# Benefits Enrollment Form

**Hired On/After 7/1/2020**

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

Employer Name: Lumberton Township School District

## EMPLOYEE/PARTICIPANT INFORMATION (Employee or Dep. 31)

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

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 #: <span style="float: right;">Work Phone #:</span>
E-mail:	PCP # (if required): Dental PCP :	Division (if any):	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	<b>Requested Effective Date:</b>		

## 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):	
Relationship:			

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	PCP # (if required):	
Relationship:			

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	PCP # (if required):	
Relationship:			

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	PCP # (if required):	
Relationship:			

PLAN SELECTIONS please Select one plan

Medical Plans

NJ Educators Health Plan\*

**\*If you elect the NJ Educators Health Plan for medical benefits, administered through the SHIF, you MUST also elect into the NJ Educators Health Plan for prescription benefits, administered through Benecard. The benefits are tied together.**

**Type of Coverage:**     Employee Only     Employee + Spouse     Employee + Child(ren)     Employee + Family  
 I wish not to enroll in any medical plan                       I wish to cancel my medical coverage

Termination of Employment  
Date: \_\_\_\_\_

**Addition of Dependent** (legal documentation required)

Marriage     Civil Union     Birth     Adoption/Guardianship/Foster Care    Date of Event: \_\_\_\_\_  
Add Coverage:                       Medical     Dental     Prescription

**Deletion of Dependent**    **Date of Event:** \_\_\_\_\_    **Dependent Name:** \_\_\_\_\_

Divorce (legal documentation required)                       Death of spouse or child     Child over age limit/ineligible  
Remove Coverage:                       Medical                       Dental     Prescription

**Other**

Dependent Age 31                       Newly Eligible (PT or FT)  
 Death (Name of Deceased): \_\_\_\_\_    Date of Death: \_\_\_\_\_  
 Other (Give Reason): \_\_\_\_\_

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. I also attest that the dependents listed here (if applicable) meet the dependent eligibility criteria of the Plan. I understand that in the event I cover any dependent that does not meet the eligibility provisions of the Plan that doing so shall invalidate their coverage and potentially my coverage and that I may be subject to penalties. I further agree that the SHIF may, at any time, request that I supply evidence that substantiates the eligibility status of any person I cover as a dependent under the Plan.

Print Name: \_\_\_\_\_ Employee Signature: \_\_\_\_\_

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

Signature of Employer Representative:

Date: