



Enrollment Form

TODAY'S DATE: _____

CLIENT INFORMATION

Lumberton TWP Board of Education

3116

Refer to plan options at end of form.

CLIENT NAME (PLAN SPONSOR / EMPLOYER)

CLIENT #

GROUP #

CARDMEMBER INFORMATION

FIRST NAME _____ MI _____ LAST NAME _____ ID # _____ SSN# _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PHONE NUMBER _____ CELL PHONE _____ EMAIL _____

COVERAGE TYPE

PLEASE CHECK ONE:

SINGLE
 CARDMEMBER/SPOUSE
 CARDMEMBER/CHILD
 CARDMEMBER/CHILDREN
 FAMILY

EFFECTIVE DATE: _____

REASON CODE

A	NEW ENROLLMENT
B	REINSTATE MEMBER
C	REINSTATE DEPENDENT / SPOUSE
D	ADD DEPENDENT / SPOUSE
E	TERMINATE COVERAGE
F	TERMINATE DEPENDENT COVERAGE
G	NAME CHANGE
H	ADDRESS CHANGE
I	GROUP CHANGE: FROM _____ TO _____

J	RDS ENROLLMENT, APPLICATION NUMBER IF APPLICABLE: _____
K	ISSUE CARD
L	DO NOT ISSUE ID CARD
M	COBRA ENROLLMENT
N	COBRA TERMINATION
O	STUDENT STATUS UPDATE
P	DISABLED DEPENDENT
Q	OVERAGE DEPENDENT**
R	DEPENDENT ADDRESS DIFFERS FROM CARDMEMBER (INCLUDE ON BACK)

ELIGIBILITY

	LAST NAME	FIRST NAME	MI	GENDER	BIRTHDATE	SSN	HICN	REASON CODES
CARDMEMBER								
02 SPOUSE								
EMAIL/PHONE*								
03 DEPENDENT								
EMAIL/PHONE*								
04 DEPENDENT								
EMAIL/PHONE*								
05 DEPENDENT								
EMAIL/PHONE*								
06 DEPENDENT								
EMAIL/PHONE*								
07 DEPENDENT								
EMAIL/PHONE*								
08 DEPENDENT								
EMAIL/PHONE*								

*OPTIONAL, ONLY IF DIFFERENT FROM CARMEMBER

COORDINATION OF BENEFITS

SECONDARY COVERAGE ID NUMBER _____ INSURANCE COMPANY _____ POLICY / GROUP# _____

EMPLOYER/PLAN SPONSOR _____ EFFECTIVE DATE _____

SIGNATURES

MEMBER SIGNATURE _____

CLIENT SIGNATURE _____

FOR INTERNAL USE ONLY:

DATE ENTERED: _____ ENTERED BY: _____ LOGGED BY: _____

Back of Enrollment Form

Dependent Address (1)
(if differs from cardmember)

FIRST NAME MI LAST NAME ID # SSN
MAILING ADDRESS CITY STATE ZIP CODE
PHONE NUMBER CELL PHONE EMAIL

Dependent Address (2)
(if differs from cardmember)

FIRST NAME MI LAST NAME ID # SSN
MAILING ADDRESS CITY STATE ZIP CODE
PHONE NUMBER CELL PHONE EMAIL

Dependent Address (3)
(if differs from cardmember)

FIRST NAME MI LAST NAME ID # SSN
MAILING ADDRESS CITY STATE ZIP CODE
PHONE NUMBER CELL PHONE EMAIL

Dependent Address (4)
(if differs from cardmember)

FIRST NAME MI LAST NAME ID # SSN
MAILING ADDRESS CITY STATE ZIP CODE
PHONE NUMBER CELL PHONE EMAIL

Dependent Address (5)
(if differs from cardmember)

FIRST NAME MI LAST NAME ID # SSN
MAILING ADDRESS CITY STATE ZIP CODE
PHONE NUMBER CELL PHONE EMAIL

Lumberton Township Board of Education

Client ID #: 3116 Group #:1000 (ACPOS \$15/\$25)

Your Co-Payment Schedule

Retail:

- \$7 for a Generic Equivalent Medication
- \$16 for a Brand Name Medication
- \$35 for a Non-Preferred Brand Name Medication

Client ID #: 3116 Group #:2000 (ACPOS \$20/\$30, QPOS \$20)

Your Co-Payment Schedule

Retail:

- \$3 for a Generic Equivalent Medication
- \$18 for a Brand Name Medication
- \$46 for a Non-Preferred Brand Name Medication

Client ID #: 3116 Group #:3000 (ACPOS \$20/\$35, QPOS \$20/\$35)

Your Co-Payment Schedule

Retail:

- \$7 for a Generic Equivalent Medication
- \$21 for a Brand Name Medication

Client ID #: 3116 Group #:4000 (ACPOS \$10, ACPOS \$15, QPOS \$10)

Your Co-Payment Schedule

Retail:

- \$3 for a Generic Equivalent Medication
- \$10 for a Brand Name Medication

Client ID #: 3116 Group #:6000 (NJ Educators Health Plan)

Your Co-Payment Schedule

Retail:

- \$5 for a Generic Equivalent Medication
- \$10 for a Brand Name Medication

