BeneCard PBF
Prescription Benefit Facilitator

Employees Hired Before 7/1/2020

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:_____

3131 Princeton Pike, Bldg. 2B, Suite 103, Lawrenceville, NJ 08648 Fax: 609-219-1660 eligibility@benecard.com www.benecardpbf.com

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