SCHOOLS HEALTH INSURANCE FUND

c/o PERMA, 401 Route 73 North,
Suite 300, Marlton, NJ 08053

Benefits Enrollment Form

Employer Name: Kingsway Regional 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: ☐ Male ☐ Female	Date of Birth:	Address:		
City:	State:	Zip:	Home Phone #:	Work Phone #:
E-mail:		PCP # (if required):	Division (if any):	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed		**Requested Effective Date:**		

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: ☐ Male ☐ Female	PCP # (if required):	

Child(ren)

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	
Relationship:			

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	
Relationship:			

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	
Relationship:			

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	
Relationship:			

Employees electing into the NJEHP or GSP for medical coverage must elect into the corresponding NJEHP or GSP prescription plan, administered by Benecard. The benefits are tied together. Employees hired on/after 7/1/2020 may only elect the NJEHP or GSP.

PLAN SELECTIONS

Medical Coverage

Carrier Name: AmeriHealth Administrators Plan Name: **Please choose from the options below**

☐ PPO $20 ☐ EPO $20/$40 ☐ EPO $30/$50 ☐ EPO HSA $1350 ☐ NJ Educators Health Plan ☐ Garden State Plan

Type of Coverage: ☐ Single ☐ Family ☐ Husband/Wife ☐ Parent/Child(ren)

____ I wish not to enroll in any medical coverage. _____I wish to cancel my medical coverage.

Prescription Coverage

Carrier Name: Express Scripts Plan Name: **Please choose from options below.**

☐ Retail $8/$18 ☐ NJ Educators Health Plan/GSP

Type of Coverage: ☐ Single ☐ Family ☐ Husband/Wife ☐ Parent/Child(ren)

____I wish not to enroll in prescription coverage. _____I wish to cancel my prescription coverage.

Dental Coverage

Carrier Name: Delta Dental Plan Name: Premier Plan

Type of Coverage: ☐ Single ☐ Family ☐ Husband/Wife ☐ Parent/Child(ren)

____I wish not to enroll in dental coverage. _____I wish to cancel my dental coverage.

TYPE OF ACTIVITY

☐ New Hire Date: _____ ☐ Open Enrollment Date: _____ ☐ Rehire Date: _____

☐ Termination of Employment
Date: _____

☐ COBRA (please check box indicating reason for COBRA eligibility):
- ☐ Employment Terminated ☐ Reduction in hours ☐ Divorce
- ☐ Spouse/dependent child of deceased employee ☐ Loss of dependent child status under plan rules
- ☐ Spouse/dependent's loss of coverage due to employee's Medicare entitlement

Addition of Dependent (legal documentation required)

☐ Marriage ☐ Civil Union ☐ Birth ☐ Adoption/Guardianship/Foster Care Date of Event: _____

Add Coverage: ☐ Medical ☐ Rx ☐ Dental

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 ☐ Rx ☐ Dental

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:_____