HA-0890-0519

School Employees' Health Benefits Program (SEHBP)

EDUCATION ACTIVE EMPLOYEE GROUP

HEALTH BENEFITS ENROLLMENT and/or CHANGE FORM

1. EMPLOYEE INFORMATION — Last Name | First | MI

Gender	Birth Date	Social Security Number	Marital Status*
	/ /	— —	

Telephone Number: ( )

Personal Email Address

Home Address No. and Street Name

City | State | Zip

2. EMPLOYMENT STATUS ☐ Full Time ☐ Part Time ☐ National Guard

3. REASON FOR APPLICATION (check one)

☐ New Enrollment ☐ Transfer
☐ Open Enrollment ☐ Loss of Coverage
☐ Adding Dependents ☐ Deleting Dependents
☐ Waiver of Coverage ☐ Other

Reason_____

Date of Event _____/_____/_____

4. TYPE and LEVEL OF COVERAGE

Level	Health	Rx*
☐ Single	☐	☐
☐ Parent/Child	☐	☐
☐ Member/Spouse/Civil Union	☐	☐
☐ Member/Domestic Partner	☐	☐
☐ Family	☐	☐

DIVISION USE ONLY

Effective Dates — Event Reason:

H ____ ____ ____

Rx ____ ____ ____

EMPLOYER CERTIFICATION

(See Instructions on reverse)

Employer Name _____

Location # (State Monthly)

10/12 - month employee *(Enter "10 or 12")*

MEMBER ACTION

☐ New Enrollment ☐ Transfer

Date Employment Began

_____/_____/_____

☐ Return from Leave of Absence

_____/_____/_____

Signature of Certifying Officer

Telephone # *Date Mailed*

I have been offered the above coverage and I elect to waive participation for myself and my eligible dependents (see Instructions page for details). **Note:** Oral contraceptive coverage is available under the medical plan.

☐ I elect to waive Health Coverage ☐ I elect to waive Prescription Drug Coverage

5. HEALTH PLAN

HORIZON		AETNA	
☐ NJ DIRECT ZERO	☐ NJ DIRECT2035	☐ Aetna Freedom Zero	☐ Aetna Freedom2035
☐ NJ DIRECT10	☐ Horizon HMO	☐ Aetna Freedom10	☐ Aetna HMO
☐ NJ DIRECT15	☐ Horizon HMO1525	☐ Aetna Freedom15	☐ Aetna HMO1525
☐ NJ DIRECT1525	☐ Horizon HMO2030	☐ Aetna Freedom1525	☐ Aetna HMO2030
☐ NJ DIRECT2030	☐ Horizon HMO2035	☐ Aetna Freedom2030	☐ Aetna HMO2035

For HMO Plans only, enter Primary Care Physician's ID # _____

6. Dependent Information: List all eligible dependents and attach required proof of dependency documents*

☐ **Additional sheets attached. Any dependents not listed will be removed.**

Eligible Dependents Last Name, First Name	Social Security No.	Circle Relationship	Birth Date	Gender
	— —	Spouse / Civil Union / Domestic Partner	/ /	
	— —	Child (Natural, Adopted, Foster, Step, Legal Ward)	/ /	
	— —	Child (Natural, Adopted, Foster, Step, Legal Ward)	/ /	

***See Instructions page for detailed information and Mailing Address**

EMPLOYEE CERTIFICATION — I certify that all the information supplied on this form is true to the best of my knowledge and that it is verifiable. I understand that if I waive my right to coverage at this time, enrollment is not permissible until the next scheduled open enrollment or if other coverage is lost and proof of loss is provided (HIPAA). I also understand that there is no guarantee of continuous participation by medical providers, either doctors or facilities, in the plans. If either my physician or medical center terminates participation in my selected plan, I must select another doctor or medical center participating in that plan to receive the "in-network" benefit. 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 assignee may require. Misrepresentation: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties pursuant to N.J.S.A.17:33A-6c.

7. Employee Signature: _____ **Date:** _____/_____/_____