SOUTHERN NEW JERSEY EMPLOYEE BENEFITS FUND

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

Employee/Participant Information (Employee)

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				

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			

Completed by Employer

Employer Name: **Pennsauken Twp.**

Action to be Taken: ☐ New Enrollment – Effective Date: _____	Signature of Certifying Officer:
☐ Return from Leave of Absence – Effective Date: _____	Phone #:
☐ Enrollment Change – Effective Date: _____	Date Mailed:

Benefit Elections

Medical Coverage or Prescription

Medical

☐ **Aetna HNO (EPO) $20/$40**

Type of Coverage: ☐ EE Only ☐ EE + Child(ren) ☐ EE + Spouse ☐ EE + Family

Prescription

☐ **Express Scripts**

Type of Coverage: ☐ EE Only ☐ EE + Child(ren) ☐ EE + Spouse ☐ EE + Family

☐ I elect not to enroll in any medical or prescription plan ☐ I wish to cancel my medical or prescription plan

Dental Coverage

☐ **Delta Dental PPO/Prem/Adv** ☐ **Delta Dental PPO**

Type of Coverage: ☐ EE Only ☐ EE + Child(ren) ☐ EE + Spouse ☐ EE + Family

☐ I elect not to enroll in any dental plan ☐ 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

Retirement Date of Retirement: _____

☐ Town Paid Benefits: ☐ Direct Bill Retiree:

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): _____

Other Group Health (If yes, please attach a copy of the front & back of the ID card for that coverage. Please indicate the name & address of the other carrier.)

☐ No ☐ Yes _____

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.

Print Name: _____ Employee Signature: _____
Date: _____