



c/o PERMA PO BOX 99106 Camden, NJ 08101

# New Hires EHP & GSP Enrollment Form

Employer Name: Black Horse Pike Regional BOE

## EMPLOYEE/PARTICIPANT INFORMATION (Employee or Dep. 31)

Please PRINT and fill this section out COMPLETELY

Social Security #:	Last Name:	First Name:	M.I.:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	Address:	
City:	State:	Zip:	Home Phone #: Work Phone #:
E-mail:	PCP # (if required):	Division (if any):	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> 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: <input type="checkbox"/> Male <input type="checkbox"/> Female	PCP # (if required):	

### Child(ren)

Social Security #:	First Name:	Last Name:	M.I.:
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	PCP # (if required):	
Relationship:			

Social Security #:	First Name:	Last Name:	M.I.:
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	PCP # (if required):	
Relationship:			

Social Security #:	First Name:	Last Name:	M.I.:
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	PCP # (if required):	
Relationship:			

Social Security #:	First Name:	Last Name:	M.I.:
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	PCP # (if required):	
Relationship:			

Social Security #:	First Name:	Last Name:	M.I.:
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	PCP # (if required):	
Relationship:			

## PLAN SELECTIONS

### Medical Coverage

**Carrier (choose one):**  Aetna - EHP  AmeriHealth - EHP  Aetna - GSP  AmeriHealth - GSP  
(NJ Providers Only) (NJ Providers Only)

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

### Prescription Coverage

**Carrier: Express Scripts - EHP/GSP**

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

### Dental Coverage

**Carrier: Delta Dental**

**Plan Name:** \_\_\_\_\_

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

### 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: \_\_\_\_\_