SCHOOLS HEALTH INSURANCE FUND

Benefits Enrollment Form

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

Employer Name: **Clayton 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: ☐ 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:			

PLAN SELECTIONS

Medical Coverage

Please select one plan:

☐ **Aetna HMO $20/$20**

☐ **Aetna HMO $20/$35**

☐ **Aetna Choice POS II $20/$20**

☐ **Aetna Choice POS II $20/$35**

☐ **Amerihealth PPO $20/$20**

☐ **Amerihealth PPO $20/$35**

__Aetna Choice POS II - New Jersey Educators Health Plan __Aetna Choice POS II Garden State Plan

__ Amerihealth PPO - New Jersey Educators Health Plan __Amerihealth PPO Garden State Plan

*All employees with a start date of employment on or after 7/1/2020 must enroll in the Aetna or Amerihealth New Jersey Educators Health Plan or the Garden State Plan

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

Non-tenured employees must select EE only coverage type.

☐ I wish to waive medical coverage ☐ I wish to cancel my medical 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 - **Date of Event:**_____ **Dependent Name:** _____

Legal Documentation is required

☐ Marriage ☐ Civil Union ☐ Birth ☐ Adoption/Guardianship/Foster Care

Add Coverage: ☐ Medical

Deletion of Dependent **Date of Event:**_____**Dependent Name:** _____

☐ Divorce (Legal Documentation is required) ☐ Death of spouse or child ☐ Child over age limit/ineligible

Remove Coverage: ☐ Medical

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:_____