Benefits Enrollment Form

Return Completed Form To:
Allie Jones at ajones@gcecnj.org

Employer Name: **<u>Gloucester County Vocational- Technical School District</u>**

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:		Medical PCP # (if required):	Dental PCP # (if required):	
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 <u>eligible</u> dependents only.

Spouse

Social Security #:	First Name:	Last Name:	M.I.:
Date of Birth:	Gender: ☐ Male ☐ Female	Medical PCP # (if required): Dental PCP # (if required):	

Child(ren)

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

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

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

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

PLAN SELECTIONS **Employees hired on/after 7/1/2020 may only elect the NJEHP or GSP for medical and prescription benefits.*

Medical & Prescription Coverage (Below includes the Aetna Gold Vision plan, except for the NJEHP and GSP plans)

Please select one plan:

- ☐ **Aetna Choice POS II Educators Plan w/Rx $5/$10**
- ☐ **Aetna Whole Health NJ Choice POS II Garden State Health w/Rx $5/$10**
- ☐ **Aetna Choice POS II $10 w/ Rx $3/$10**
- ☐ **Aetna QPOS $10 w/ Rx $3/$10**
- ☐ **Aetna Choice POS II $15 w/ Rx $3/$10**
- ☐ **Aetna QPOS $15/$25 w/ Rx $7/$16/$35**
- ☐ **Aetna Choice POS II $15/$25 w/ Rx $7/$16/$35**
- ☐ **Aetna QPOS $20/$35 w/ Rx $7/$21**
- ☐ **Aetna Choice POS II $20/$35 w/ Rx $7/$21**
- ☐ **Horizon OMNIA w/ Rx $3/$10**

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

☐ I wish to waive medical and prescription coverage ☐ I wish to cancel my medical and prescription coverage

Medical ONLY Coverage (Below includes the Aetna Gold Vision plan)

Please select one plan:

- ☐ **Aetna Choice POS II $10**
- ☐ **Aetna Choice POS II $15**
- ☐ **Aetna Choice POS II $15/$25**
- ☐ **Aetna Choice POS II $20/$35**
- ☐ **Aetna QPOS $10**
- ☐ **Aetna QPOS $15/$25**
- ☐ **Aetna QPOS $20/$20**
- ☐ **Horizon OMNIA**

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

☐ I wish to waive my medical only coverage ☐ I wish to cancel my medical only coverage

Prescription ONLY Coverage

Please select one plan:

- ☐ **Express Scripts $3/$10**
- ☐ **Express Scripts $7/$21**
- ☐ **Express Scripts $7/$16/$35**
- ☐ **Express Scripts $3/$18/$46**

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

☐ I wish to waive my prescription only coverage ☐ I wish to cancel my prescription only coverage

Dental Coverage

☐ **Delta Dental PPO/Premier/Advantage** ☐ **DeltaCare USA DMO**

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

☐ I wish to waive 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 ☐ Prescription ☐ 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 ☐ Prescription ☐ 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:_____