NEW JERSEY LEAGUE ENROLLMENT/CHANGE FORM

FORM MUST BE RECEIVED BY THE 24TH OF THE MONTH TO BE INCLUDED ON CURRENT INVOICE. TRANSACTIONS FOR FORMS RECEIVED AFTER THE 24TH WILL APPEAR ON A SUBSEQUENT INVOICE.

Employer Name

☐ OPEN ENROLLMENT ☐ CHANGE
☐ NEW ENROLLMENT ☐ REINSTATE

Insured Status
☐ EMPLOYEE ☐ RETIREE
☐ DIRECTOR ☐ SURVIVOR

Date of Hire | **Social Security Number**

Employee Name (Last) **(First)** **(M.I.)** **(Date of Birth)**

IF MEDICARE ELIGIBLE, PLEASE CHECK ☐ PART A ☐ PART B

Address (Street) **(Apt No.)** **(City)** **(State)** **(Zip)**

TYPE OF CHANGE

☐ **Add Dependent(s)**
- ☐ Birth ☐ Marriage
- ☐ Adoption Placement
- ☐ Other ___________________
- ☐ Date ___________________

☐ **Address Change**

☐ **Name Change**

Indicate Change Above

☐ **Cancel Dependent(s)***
- ☐ Divorce/Separation ☐ Child Attained Age
- ☐ Death ☐ Medicare
- ☐ Retirement ☐ Military Service
- ☐ Other _________________

***Attach coverage continuance form to insure proper COBRA Notification**

☐ **Transfer to COBRA***
- ☐ 18 months
- ☐ 29 months
- ☐ 36 months

***Attach coverage continuance form to insure proper COBRA Notification**

☐ **Retirement**

☐ **Other** __________________

	EFFECTIVE DATE	SINGLE	PARENT/CHILD	HUSBAND/WIFE	FAMILY	PREVIOUS COVERAGE
HEALTH CARE						

Please print (Specify last name if different from employee's) Last Name First Name M.I.	DATE OF BIRTH Mo. Day Year	SEX	FULL-TIME STUDENT?	SOCIAL SECURITY NUMBER	*Enter your Primary Care Physician (PCP) & OB/GYN ID Numbers Below If applicable to your plan.*		Existing Patient? PCP	Existing Patient? OB/GYN
Employee		M F			PCP	OB/GYN	Yes No	Yes No
Spouse		M F			PCP	OB/GYN	Yes No	Yes No
Dependent		M F	Yes No		PCP	OB/GYN	Yes No	Yes No
Dependent		M F	Yes No		PCP	OB/GYN	Yes No	Yes No
Dependent		M F	Yes No		PCP	OB/GYN	Yes No	Yes No

SIGNATURE - I hereby enroll for benefits for which I am presently eligible. I certify that the above information is to the best of my knowledge true and complete.

EMPLOYEE'S SIGNATURE / DATE

<u>NOTICE OF ENROLLMENT RIGHTS</u> If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. You and/or your dependents (including spouse) may also have the opportunity to apply for this coverage during an open enrollment period for your group to be effective on the date of such enrollment.

I, the undersigned employee, understand my Enrollment Rights as stated. I have been offered and elect to decline coverage under the benefit plan as indicated below.

Health Care I decline coverage for Self Dependents

SIGNATURE ____ DATE ________________________

I am declining coverage for the following reason:

I currently have coverage provided by ____

Other ____