

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		Insured Status	
<input type="checkbox"/> OPEN ENROLLMENT	<input type="checkbox"/> CHANGE	<input type="checkbox"/> EMPLOYEE	<input type="checkbox"/> RETIREE
<input type="checkbox"/> NEW ENROLLMENT	<input type="checkbox"/> REINSTATE	<input type="checkbox"/> DIRECTOR	<input type="checkbox"/> SURVIVOR
Date of Hire		Social Security Number	
Employee Name (Last)	(First)	(M.I.)	(Date of Birth)
			IF MEDICARE ELIGIBLE, PLEASE CHECK
			<input type="checkbox"/> PART A <input type="checkbox"/> PART B
Address (Street)		(Apt No.)	(City)
		(State)	(Zip)
TYPE OF CHANGE			
<input type="checkbox"/> Add Dependent(s) <input type="checkbox"/> Birth <input type="checkbox"/> Marriage <input type="checkbox"/> Adoption Placement <input type="checkbox"/> Other _____ <input type="checkbox"/> Date _____		<input type="checkbox"/> Address Change <input type="checkbox"/> Name Change <i>Indicate Change Above</i>	
		<input type="checkbox"/> Cancel Dependent(s)* <input type="checkbox"/> Divorce/Separation <input type="checkbox"/> Child Attained Age <input type="checkbox"/> Death <input type="checkbox"/> Medicare <input type="checkbox"/> Retirement <input type="checkbox"/> Military Service <input type="checkbox"/> Other _____	
		<input type="checkbox"/> Transfer to COBRA* <input type="checkbox"/> 18 months <input type="checkbox"/> 29 months <input type="checkbox"/> 36 months	
		<input type="checkbox"/> Retirement <input type="checkbox"/> Other _____	
		*Attach coverage continuance form to insure proper COBRA Notification	
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	EFFECTIVE DATE	SINGLE	PARENT/CHILD	HUSBAND/WIFE	FAMILY	PREVIOUS COVERAGE
HEALTH CARE _____						
DENTAL						
<input type="checkbox"/> VISION <input type="checkbox"/> EAP <i>(Stand Alone Plans)</i>						

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 <u>ID Numbers</u> Below If applicable to your plan.		Existing Patient?	
							PCP	OB/GYN
Employee		<input type="checkbox"/> M <input type="checkbox"/> F			PCP	OB/GYN	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse		<input type="checkbox"/> M <input type="checkbox"/> F			PCP	OB/GYN	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No		PCP	OB/GYN	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No		PCP	OB/GYN	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No		PCP	OB/GYN	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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

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 Dental I decline coverage for Self Dependents

SIGNATURE _____ DATE _____

I am declining coverage for the following reason:

I currently have coverage provided by _____

Other _____

NOTICE OF ENROLLMENT RIGHTS 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.