2025 ENROLLMENT FORM

Please fill out each section of this form, *even if you are waiving any/all coverage*. Don't forget to sign and date the back! Submit your completed forms to the Personnel Department.

SECTION A: EMPLOYEE INFORMATION

PLEASE PROVIDE ALL REQUESTED INFORMATION

Name (Last, First, MI)		Marital Status: ☐ Single ☐ Married ☐ Civil Union ☐ Divorced	
Street Address	City	State	Zip
Social Security Number	Date of Birth	Date of Hire	
Phone Number	Gender		

SECTION B. 2025 MEDICAL/PRESCRIPTION DRUG COVERAGE OPTIONS

***PLEASE NOTE:* When you enroll in a medical plan you will be automatically enrolled in the corresponding prescription plan through Benecard.**

PLEASE CHECK (✓) ONE BOX

CARRIER	EMPLOYEE	EMPLOYEE + SPOUSE/ CIVIL UNION PARTNER	EMPLOYEE + CHILD(REN)	FAMILY	WAIVE
Horizon NJ Direct 10 Benecard Rx	☐	☐	☐	☐	☐
Horizon NJ Direct 15 Benecard Rx	☐	☐	☐	☐	☐
Horizon NJEHP Benecard Rx	☐	☐	☐	☐	☐
Horizon NJGSP Benecard Rx	☐	☐	☐	☐	☐

SECTION C. 2025 DENTAL COVERAGE OPTION

PLEASE CHECK (✓) ONE BOX

CARRIER	EMPLOYEE	EMPLOYEE + SPOUSE/ CIVIL UNION PARTNER	EMPLOYEE + CHILD(REN)	FAMILY	WAIVE
Delta Dental PPO	☐	☐	☐	☐	☐

SECTION D. 2025 VISION COVERAGE OPTION

PLEASE CHECK (✓) ONE BOX

CARRIER	EMPLOYEE	EMPLOYEE + SPOUSE/ CIVIL UNION PARTNER	EMPLOYEE + CHILD(REN)	FAMILY	WAIVE
NVA	☐	☐	☐	☐	☐

IMPORTANT: Only your eligible dependents may be enrolled for coverage. Supporting documentation must be submitted in order to verify your dependent's eligibility.

ELIGIBLE DEPENDENTS:	REQUIRED SUPPORTING DOCUMENTATION:
Your spouse/civil union partner	• Marriage certificate or license • Civil union partnership certificate • Divorce decree
Your natural child(ren), stepchild(ren), legally adopted child(ren), child(ren) in which you have legal guardianship	• Birth certificate • Tax return • Proof of dependent child's continued disability if 26 years of age or older • Legal document for court-appointed guardianship • Final adoption certificate • Legal adoption agency or placement document • Qualified Medical Child Support Order (QMCSO)

SECTION E. DEPENDENT INFORMATION (Indicate dependents that you want covered by your medical, dental or vision plans)

LAST NAME, FIRST NAME, MI	GENDER	DATE OF BIRTH	SOCIAL SECURITY NUMBER	COVERAGE
Spouse/Partner	☐ Male ☐ Female	/ /		☐ Medical/Rx ☐ Dental ☐ Vision
Child	☐ Male ☐ Female	/ /		☐ Medical/Rx ☐ Dental ☐ Vision
Child	☐ Male ☐ Female	/ /		☐ Medical/Rx ☐ Dental ☐ Vision
Child	☐ Male ☐ Female	/ /		☐ Medical/Rx ☐ Dental ☐ Vision
Child	☐ Male ☐ Female	/ /		☐ Medical/Rx ☐ Dental ☐ Vision

*** If enrolling more than four children, please attach a separate sheet of paper with the above information.**

APPLICANT STATEMENT OF UNDERSTANDING

I hereby declare, under penalty of perjury, that the information that I provided on this form is accurate and complete, and if applicable, that the dependents that I am enrolling in coverage or opting out of coverage are my legal dependents and meet the definitions outlined in the plan documents.

If I am opting out myself or any of my dependents, I attest that I/we have alternative and comparable coverage from an alternative source for the upcoming plan year. I understand that if I lose this coverage during the upcoming plan year, that it is my responsibility to inform the Berkeley Township School District within 30 days, so that I, or any of my eligible family members, may become covered under the Berkeley Township School District Plan. I understand that the Berkeley Township School District reserves the right to require proof of valid dependent eligibility status in conjunction with the operation of both its benefit and opt out programs and if I fail to provide the necessary required documentation, then the Berkeley Township School District will terminate coverage for these dependents. Further, I understand that I will be required to reimburse the Berkeley Township School District for all insurance premiums or opt out dollars paid if the Berkeley Township School District determines that my dependents were not eligible for coverage or if we did not have alternative and comparable coverage.

I understand that IRS §125 prohibits me from changing my enrollment during the Plan Year, unless I experience a qualifying life event. A qualifying event includes a marriage, divorce, death of a spouse/civil union partner or a dependent, birth or adoption of a child, termination, or commencement of employment for my spouse/civil union partner, a change in employment status (full-time to part-time or part-time to full-time) for me or my spouse/civil union partner that affects benefits eligibility, or taking an unpaid, medical leave of absence by either me or my spouse/civil union partner. If I experience one of these qualifying events, I understand that I am obligated to notify the Human Resources Department within 30 days and that failure to do so may affect benefits coverage.

My signature below indicates that I have read and understood this Enrollment & Authorization Form and the descriptive materials made available to me under the Berkeley Township School District Employee Benefits Program. I understand that if I elect medical, prescription drug, dental and/or vision benefits that require employee contributions, my employer will deduct this amount from my before-tax income. I also understand that this salary reduction authorization can only be changed during initial enrollment periods, unless I have a change in family status as defined by law. I certify that the information that I have provided on this form is complete and accurate to the best of my knowledge.

PRINT Employee Name	**Employee Signature**	**Date**

FOR HUMAN RESOURCES ONLY (To be completed by employer. Employer signature required.)

Date Received:	Received By:	Benefits Effective Date: