Cumberland Regional School District

HEALTHCARE ENROLLMENT/CHANGE FORM

Type of Activity — Please check all that apply.

Activity	Medical	Prescription	Dental	Effective Date	Reason (Select from Drop Down List)
☐ New Enrollment*	☐	☐	☐		
☐ Add Spouse/Domestic Partner/Dependent*	☐	☐	☐		
☐ Change Plan	☐	☐	☐		
☐ Terminate Coverage	☐	☐	☐		
☐ Remove Spouse/Domestic Partner/Dependent*	☐	☐	☐		
☐ Reinstate coverage	☐	☐	☐		
☐ Other:	☐	☐	☐		

Attach appropriate documentation (i.e., Birth Certificates, Marriage Certificate, etc.)

Employee Information — Please fill out **COMPLETELY**.

Social Security #	Last Name	First Name	MI	Date of Birth	Gender
					☐ Male ☐ Female

Address of Employee (if any dependents live at a different address, list other address below)	City	State	Zip	Home/Cell Phone #

Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Widowed

Change Due to Medicare Status?
☐ No ☐ Yes (attach copy of Medicare Card)

Are You Medicare Eligible?
☐ No ☐ Yes because of age ☐ Yes because of disability

Is Your Spouse Medicare eligible?
☐ No ☐ Yes because of age ☐ Yes because of disability

Member Information — **List eligible dependents only.** Must provide copy of birth certificate for children and a marriage certificate for spouse. Provide copy of court order or residency for stepchildren or foster children.

	Add	Change	Remove	Last Name, First Name, MI	Gender	Birthdate	Social Security No.	Aetna PCP # (www.aetna.com/docfind) If none given, you will be randomly assigned one.	Current Patient? Y	Current Patient? N	Same Address as Employee? Y	Same Address as Employee? N*	Med	Rx	Dental
Self	☐	☐	☐		☐M ☐F				☐	☐			☐	☐	☐
Spouse	☐	☐	☐		☐M ☐F				☐	☐	☐	☐	☐	☐	☐
Child	☐	☐	☐		☐M ☐F				☐	☐	☐	☐	☐	☐	☐
Child	☐	☐	☐		☐M ☐F				☐	☐	☐	☐	☐	☐	☐
Child	☐	☐	☐		☐M ☐F				☐	☐	☐	☐	☐	☐	☐
Child	☐	☐	☐		☐M ☐F				☐	☐	☐	☐	☐	☐	☐

*If not living at same address as employee, write address here:

Benefit Elections — If you were hired on or after 7/1/2020, you **MUST** elect either the NJEHP Medical Plan and NJEHP/Garden State Rx Plan together or the Garden State Medical Plan and NJEHP/Garden State Rx Plan together. You may not elect any other Medical or Rx plan.

Type	Election	Coverage Level	Plans
Medical	☐ Enroll ☐ Waive*	☐ Single ☐ Couple ☐ Parent/Child(ren) ☐ Family	☐ QPOS Patriot X ☐ *NJEHP* ☐ QPOS Patriot XV** ☐ *Garden State Plan* ☐ PPO Core A ☐ PPO Care B
Prescription	☐ Enroll ☐ Waive*	☐ Single ☐ Couple ☐ Parent/Child(ren) ☐ Family	☐ Base Plan ☐ *NJEHP/Garden State Plan*
Dental	☐ Enroll ☐ Waive*	☐ Single ☐ Couple ☐ Parent/Child ☐ Three+	☐ Delta Premier

* Attach copy of ID card showing other coverage and complete the cash-in-lieu waiver form.
**If newly electing Patriot XV, contact HR for "buy-up" form–additional payroll deductions apply.

Employee Certification

I understand 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 unless I experience an eligible life-changing event. I understand that there is no guarantee of continuous participation by service providers, doctors or facilities in the Plans. I authorize any hospital, physician or health care provider to furnish my Plans or its assignee with such medical/prescription/dental information about myself or my covered dependents as the Plans or assignees may require.

Employee Signature: Date: