Open Enrollment Effective: 1/1/2026

School Employees' Health Benefits Program (SEHBP)

EDUCATION ACTIVE EMPLOYEE GROUP

HEALTH BENEFITS ENROLLMENT AND/OR CHANGE FORM

MEMBER INFORMATION				
Employee Name				
Gender	SSN	DOB	Marital Status	
Phone Number		Email Address		
Street Address		City	State	Zip Code

OFFICE USE ONLY

Effective Dates:
H _____ /_____ / _____
Rx _____ /_____ / _____

Event Reason:
_____

Date Employment Began:
_____ /_____ / _____

_____
Signature of Certifying Officer

EMPLOYMENT STATUS

☐ Full Time ☐ Part Time

LEVEL OF COVERAGE

☐ Single
☐ Parent/Child
☐ Member/Spouse/Civil Union
☐ Member/Domestic Partner
☐ Family

REASON FOR APPLICATION (CHECK ONE)

☐ New Enrollment ☐ Loss of Coverage
☐ Open Enrollment ☐ Deleting Dependents
☐ Adding Dependents ☐ Transfer
☐ Other _____

_____

Date of Event _____ /_____ /_____

HEALTH PLAN (CHECK ONE)

Horizon Options:
☐ New Jersey Educators Plan - Horizon
☐ Direct 10
☐ Direct 15

Aetna Options:
☐ New Jersey Educators Plan - Aetna
☐ Freedom 10
☐ Freedom 15
☐ Garden State Health Plan

******NJ DIRECT 10 + 15 AND FREEDOM 10 + 15 ARE ONLY AVAILABLE TO EMPLOYEES HIRED PRIOR TO JULY 1, 2020******

DEPENDENT INFORMATION (Please list all eligible dependents and attach required proof of dependency documents)

Eligible Dependents' Names	Gender	DOB	SSN	Relationship (Please Circle)
				Spouse / Civil Union / Domestic Partner
				Natural / Adopted / Foster / Step / Legal
				Natural / Adopted / Foster / Step / Legal
				Natural / Adopted / Foster / Step / Legal
				Natural / Adopted / Foster / Step / Legal
				Natural / Adopted / Foster / Step / Legal
				Natural / Adopted / Foster / Step / Legal

MEMBER CERTIFICATION - I certify that all the information supplied on this form is true to the best of my knowledge and that it is verifiable. I understand that if I waive my right to coverage at this time, enrollment is not permissible until the next scheduled open enrollment or if other coverage is lost and proof of loss is provided (HIPAA). I also understand that there is no guarantee of continuous participation by medical providers, either doctor or medical center participating in that plan to receive the in-network benefit. 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 assignee may require. Misrepresentation: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties pursuant to N.J.S.A 17:33A-6c

_____ _____
Employee Signature **Date**