

Enrollment Form



EMPLOYEE INFORMATION Please provide all requested information.

Last name:	First name:	M.I.:	Social Security Number:	Marital Status:				
				<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Civil Union	<input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Divorced
Address:			Date of Birth:	Gender:	Date of Hire:			
City:			State:	Zip:	Home Phone Number:			
Employee ID:				Title:				

TYPE OF ENROLLMENT – ACTION TO BE TAKEN:

<input type="checkbox"/> New Hire	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Life Event	<input type="checkbox"/> Address Change
Effective Date: _____	Effective Date: _____	Effective Date: _____	Effective Date: _____

IMPORTANT: Proof of a life event is required! Please provide documentation (Required Social Security Card, W2, or Joint Debt, divorce decree, birth certificate, adoption paperwork, etc.) to Human Resources within 60 days of your life event or coverage will be affected.

MEDICAL/PRESCRIPTION COVERAGE OPTIONS: Please check (✓) one box.

Horizon Plan Options	Single	Parent/Child	EE + Spouse / Civil Union / Domestic Partner	Family
Horizon Direct Access \$10 Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Horizon Direct Access \$15 Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Horizon EHP (Educators Plan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Horizon GSP (Garden State Plan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I elect to waive medical/Rx coverage in any medical plan.

Name: _____ Social Security Number: _____ - _____ - _____

DEPENDENT INFORMATION* Please provide all requested information and check (✓) all boxes that apply.

Dependent's First Name, Middle Initial, and Last Name	Relationship SP = Spouse CU = Civil Union DP = Domestic Partner C = Child	Date of Birth (MM/DD/YYYY)	Social Security Number	Gender (M/F)	Medical	Dental
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>

I elect to waive medical coverage in any medical plan.

* If enrolling more than five (5) dependents for coverage, please write all information on an additional sheet of paper.

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 Ocean Township School District within 30 days, so that I, or any of my eligible family members, may become covered under the Ocean Township School District Plan. I understand that the Ocean 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 Ocean Township School District will terminate coverage for these dependents. Further, I understand that I will be required to reimburse the Ocean Township School District for all insurance premiums or opt out dollars paid if the Ocean 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/domestic partner or a dependent, birth or adoption of a child, termination, or commencement of employment for my spouse/civil union/domestic partner, a change in employment status (full-time to part-time or part-time to full-time) for me or my spouse/civil union/domestic partner that affects benefits eligibility, or taking an unpaid, medical leave of absence by either me or my spouse/civil union/domestic partner. If I experience one of these qualifying events, I understand that I am obligated to notify Human Resources 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 Ocean Township School District Employee Benefits Program. I understand that if I elect medical, prescription drug 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.

Signature: _____

FOR HUMAN RESOURCES USE ONLY:		
Date Received: _____	Received By: _____	Benefits Effective Date: _____
Employee Type:	<input type="checkbox"/> 10-month employee	<input type="checkbox"/> 12-month employee