SCHOOLS HEALTH INSURANCE FUND

c/o PERMA, PO Box 99106
Camden, NJ 08101

2024-25 Open Enrollment

Benefits Enrollment Form

Employer Name: Colts Neck BOE

EMPLOYEE/PARTICIPANT INFORMATION (Employee or Dep. 31)

Please **PRINT** and fill this section out **COMPLETELY**

Social Security #:	Last Name:		First Name:	M.I.:
Gender: ☐ Male ☐ Female	Date of Birth:		Address:	
City:	State:	Zip:	Home Phone #:	Work Phone #:
E-mail:	PCP # (if required):		Division (if any):	
	Requested Effective Date: 07/01/2024			

DEPENDENT INFORMATION (Spouse, Child or Children)

Please **PRINT** and fill this section out **COMPLETELY**

Please list all eligible dependents only.

Spouse

Social Security #:	First Name:	Last Name:	M.I.:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	

Child(ren)

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	
Relationship:			
Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	
Relationship:			
Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	
Relationship:			
Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	
Relationship:			

PLAN SELECTIONS – please Select one plan

Medical and Prescription Coverage

☐ **Aetna Choice POS II $10 with Prescription Drug 10%**

☐ **Aetna Choice POS II $10 with Prescription Drug $5/$10/$20**

☐ **Aetna Choice POS II $15 with Prescription Drug 10%**

☐ **Aetna Choice POS II $15 with Prescription Drug $5/$10/$20**

☐ **Aetna Choice POS II $15/$25 with Prescription Drug 15%**

☐ **Aetna Choice POS II $20/$20 with Prescription Drug 15%**

☐ **Aetna Choice POS II $20/$35 with Prescription Drug $7/$21**

☐ **Aetna Choice POS II –Educators Plan with Prescription Drug $5/$10**

☐ **Aetna QPOS $10 with Prescription Drug $5/$10/$20**

☐ **Horizon OMNIA with Prescription Drug $5/$10/$20**

☐ **Aetna Garden State with Prescription Drug $5/$10**

Type of Coverage: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family

☐ I wish not to waive medical & prescription coverage ☐ I wish to cancel my medical & prescription coverage

---

TYPE OF ACTIVITY

☐ New Hire Date: _____ ☒ Open Enrollment Date: _07/01/2024_____ ☐ Rehire Date: _____

☐ Termination of Employment
Date: _____

Addition of Dependent (legal documentation required)

☐ Marriage ☐ Civil Union ☐ Birth ☐ Adoption/Guardianship/Foster Care Date of Event: _____

Add Coverage: ☐ Medical ☐ Prescription

Deletion of Dependent **Date of Event:** _____ **Dependent Name:** _____

☐ Divorce (legal documentation required) ☐ Death of spouse or child ☐ Child over age limit/ineligible

Remove Coverage: ☐ Medical ☐ Prescription

Other

☐ Dependent Age 31 ☐ Newly Eligible (PT or FT)

☐ Death (Name of Deceased): _____ Date of Death: _____

☐ Other (Give Reason):

EMPLOYEE CERTIFICATION

I certify 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. I understand that there is no guarantee of continuous participation by medical service providers, doctors or facilities in the Plans. If either my physician or medical center terminates participation in the Plan, I must select another doctor or medical center participating in the same plan. 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 medical plans or assignee may require. I also attest that the dependents listed here (if applicable) meet the dependent eligibility criteria of the Plan. I understand that in the event I cover any dependent that does not meet the eligibility provisions of the Plan that doing so shall invalidate their coverage and potentially my coverage and that I may be subject to penalties. I further agree that the SHIF may, at any time, request that I supply evidence that substantiates the eligibility status of any person I cover as a dependent under the Plan.

Print Name: _____Employee Signature: _____Date_____