



School Employees' Health Benefits Program (SEHBP)

EDUCATION ACTIVE EMPLOYEE GROUP

**HEALTH BENEFITS ENROLLMENT AND/OR CHANGE FORM**

MEMBER INFORMATION				OFFICE USE ONLY	
Employee Name				Effective Dates: H ____/____/____ Rx ____/____/____	
Gender	SSN	DOB	Marital Status		
Phone Number		Email Address			
Street Address		City	State	Zip Code	
				Event Reason: _____	
				Date Employment Began: ____/____/____	
				Signature of Certifying Officer _____	

EMPLOYMENT STATUS	REASON FOR APPLICATION (CHECK ONE)	HEALTH PLAN (CHECK ONE)
<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	<input type="checkbox"/> New Enrollment <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Deleting Dependents <input type="checkbox"/> Adding Dependents <input type="checkbox"/> Transfer <input type="checkbox"/> Other _____ _____ Date of Event ____/____/____	<b>Horizon Options:</b> <input type="checkbox"/> New Jersey Educators Plan - Horizon <input type="checkbox"/> Direct 10 <input type="checkbox"/> Direct 15 <b>Aetna Options:</b> <input type="checkbox"/> New Jersey Educators Plan - Aetna <input type="checkbox"/> Freedom 10 <input type="checkbox"/> Freedom 15 <input type="checkbox"/> Garden State Health Plan
LEVEL OF COVERAGE		
<input type="checkbox"/> Single <input type="checkbox"/> Parent/Child <input type="checkbox"/> Member/Spouse/Civil Union <input type="checkbox"/> Member/Domestic Partner <input type="checkbox"/> Family		

**\*\*\*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