EDUCATION ACTIVE EMPLOYEE GROUP
HEALTH BENEFITS ENROLLMENT and/or CHANGE FORM

1. EMPLOYEE INFORMATION — Last Name | First | MI

Gender	Birth Date	Social Security Number	Marital Status*
	/ /	— —	

Telephone Number: ( )

Personal Email Address:

Home Address No. and Street Name:

City | State | Zip

2. EMPLOYMENT STATUS ☐ Full Time ☐ Part Time ☐ National Guard

3. REASON FOR APPLICATION (check one)

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

Reason_____

Date of Event _____/_____/_____

4. TYPE and LEVEL of COVERAGE

Level	Health	Rx*
☐ Single	☐	☐
☐ Parent/Child	☐	☐
☐ Member/Spouse/Civil Union	☐	☐
☐ Member/Domestic Partner	☐	☐
☐ Family	☐	☐

DIVISION USE ONLY

Effective Dates — Event Reason:
H ___ ___ ___
Rx ___ ___ ___

EMPLOYER CERTIFICATION
(See Instructions on reverse)

Employer Name _____

Location # (State Monthly)

10/12 - month employee *(Enter "10 or 12")*

MEMBER ACTION

☐ New Enrollment ☐ Transfer

Date Employment Began

_____/_____/_____

☐ Return from Leave of Absence

_____/_____/_____

Signature of Certifying Officer

Telephone # *Date Mailed*

I have been offered the above coverage and I elect to waive participation for myself and my eligible dependents (see Instructions page for details). **Note:** Oral contraceptive coverage is available under the medical plan.

☐ I elect to waive Health and Prescription Drug Coverage

5. HEALTH PLAN AND RX COVERAGE

☐ GARDEN STATE PLAN WITH RX PLAN 299
☐ EDUCATORS HEALTH PLAN WITH RX PLAN 298

ANCILLARY COVERAGES

☑ METLIFE SUPERIOR VISION 12/12/12
☑ HEALTHCARE 2U

6. Dependent Information: List all eligible dependents and attach required proof of dependency documents*

☐ **Additional sheets attached. Any dependents not listed will be removed.**

Eligible Dependents Last Name, First Name	Social Security No.	Circle Relationship	Birth Date	Gender
	— —	Spouse / Civil Union / Domestic Partner	/ /	
	— —	Child (Natural, Adopted, Foster, Step, Legal Ward)	/ /	
	— —	Child (Natural, Adopted, Foster, Step, Legal Ward)	/ /	

***See Instructions page for detailed information and Mailing Address**

EMPLOYEE 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 doctors or facilities, in the plans. If either my physician or medical center terminates participation in my selected plan, I must select another 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.

7. Employee Signature: _____ **Date:** _____/_____/_____

PRESCRIPTION BENEFIT PLAN ENROLLMENT FORM

PROACT PHARMACY BENEFIT MANAGEMENT

EMPLOYER NAME	Type of Request	Type of Change	New Add/Change Effective
Bayonne Board of Education	☐ Add ☐ Terminate ☐ Change ☐ New Card	☐ Name ☐ Address ☐ Spouse ☐ Dependent	_____/_____/_____ **Termination Effective Date** _____/_____/_____
PLAN/DIVISION CODE 201 298 299			

Employee SS#			
Employee Last Name	First Name	MI	Employee's Date of Birth
Address		Telephone Number	
City	State	Zip	Sex
Email Address:			

List all eligible dependents to be covered in order of age (including spouse)

Relationship	Full Time Student	Last Name (if Different)	First Name	MI	Date of Birth	Gender
Spouse	☐ YES ☐ NO					
Dependent	☐ YES ☐ NO					
Dependent	☐ YES ☐ NO					
Dependent	☐ YES ☐ NO					

Do you have prescription coverage under another group insurance plan, HMO, or government plan? Yes____No____

If Yes, please answer A and B below.

A. Identify insurance carrier name and address:_____

B. Type of other coverage: ☐ Comprehensive Major Med (with Rx coverage) ☐ Major Medical only ☐ Other

Spouse's Employer_____ Spouse's Insurance Carrier_____

Spouse's Employer Address_____

Are any other dependents other than spouse listed above covered by other group insurance plan? Yes____No____

If Yes, Name of Insurer/Address/Policy Number:_____

- I authorize the representatives of ProAct to examine all records with respect to myself or any of my dependents which may have a bearing on the benefits payable under the contract(s) applied for.
- I understand that such a contract(s) applied for shall not become effective unless this application is accepted, and no benefits shall be available prior to the effective date(s) set forth in the certificate issued.

Signature of Employee:_____ Date:_____

Signature of Authorized Employer Representative: _____ Date:_____

For ProAct Use Only

Date Received_____ Date and Time Completed_____ Cov Code:_____

ProAct Representative's Signature_____ HQ Code:_____

DELTA DENTAL
DENTAL ENROLLMENT FORM

Eight Digit Group Number

Delta Dental PPO℠ plus Premier/ Advantage Program
7665 – 0006 (All Others)

Delta Dental PPO℠ plus Premier/ Advantage Program
7665 – 0007 (Maintenance Dept.)

Name of Employer	Effective Date of Coverage
BAYONNE BOARD OF EDUCATION	/

GENERAL INFORMATION - THIS SECTION MUST BE COMPLETED - PLEASE PRINT CLEARLY

Name (Last) (First) (Middle)	Date of Birth	Social Security Number
	___/___/___	___-___-___

Street Address	City, State, Zip	County

Date of Employment	Type of Coverage	Marital Status	Home Telephone
09/01/2020	☐ Single ☐ Parent/Child ☐ Husband/Wife ☐ Parent/Children ☐ Family	☐Single ☐Married ☐Divorced/Separated	( )

Enrollment	First Name - Last Name	Social Security Number	Date of Birth	Full-Time Student
Subscriber		___-___-___	/ /	
Spouse*		___-___-___	/ /	
Dependent		___-___-___	/ /	☐ Yes ☐ No
Dependent		___-___-___	/ /	☐Yes ☐No
Dependent		___-___-___	/ /	☐Yes ☐No
Dependent		___-___-___	/ /	☐Yes ☐No

* If spouse has other dental coverage, please list name and address of employer and other carrier:

I hereby represent that all information furnished is true and complete to the best of my knowledge and authorize my employer to make any required deduction from my wages.

Subscriber Signature _____ Date _____

Delta Use Only

Entered _____

Operator # _____

_____ I ELECT TO WAIVE MY DELTA DENTAL INSURANCE