Gateway / BMED Regional Health Insurance Fund

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

Employee/Participant Information (Active, 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):	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Are you or your spouse Medicare eligible? You: ☐ No ☐ Yes because of age ☐ Yes because of disability Spouse: ☐ No ☐ Yes because of age ☐ Yes because of disability		

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 # or dental office # (if required):	

Child(ren)

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # or dental office # (if required):	
Full-Time Student? ☐ Yes ☐ No			

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # or dental office # (if required):	
Full-Time Student? ☐ Yes ☐ No			

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # or dental office # (if required):	
Full-Time Student? ☐ Yes ☐ No			

Completed by Employer

Employer Name: **Plainfield BOE**

Action to be Taken: ☐ New Enrollment – Effective Date: __________________	Signature of Certifying Officer:
☐ Return from Leave of Absence – Effective Date: __________________	Phone #:
☐ Enrollment Change – Effective Date: __________________	Date Mailed:

Benefit Elections

Medical

Please select one plan that you would like to enroll:

☐ **Aetna Choice POS II $15 (300)** ☐ **Aetna Choice POS II $5** ☐ **Aetna HMO**

☐ **Aetna Choice POS II $10** ☐ **Aetna HNO (Savings Plus)**

☐ **Aetna ACPOS II Educators Plan**

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

☐ I elect not to enroll in a medical plan ☐ I wish to cancel my medical plan

Dental

☐ **Delta Dental PPO/Prem/Advantage** ☐ **Delta Care USA (DMO)**

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

☐ I elect not to enroll in a dental plan ☐ I wish to cancel my dental plan

Type of Activity

☐ New Hire Date: _____ ☐ Open Enrollment Date: _____ ☐ Rehire Date: _____

☐ Termination of Employment
Date: _____

☐ COBRA (please check box indicating reason for COBRA eligibility):
- ☐ Employment Terminated ☐ Reduction in hours ☐ Divorce
- ☐ Spouse/dependent child of deceased employee ☐ Loss of dependent child status under plan rules
- ☐ Spouse/dependent's loss of coverage due to employee's Medicare entitlement

Addition of Dependent (legal documentation required)

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

Add Coverage: ☐ Medical ☐ Dental

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 ☐ Dental

Other

☐ Dependent Age 31 ☐ Newly Eligible (PT or FT) ☐ Death (Name of Deceased: _____ Date of Death: _____

☐ Other (Give Reason): _____

Other Group Health (If yes, please attach a copy of the front & back of the ID card for that coverage. Please indicate the name & address of the other carrier.)

☐ No ☐ Yes _____

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.

Print Name: _____ Employee Signature: _____ Date: _____