



# TOMS RIVER REGIONAL SCHOOLS

1144 Hooper Avenue  
Toms River, NJ 08753

## Health Insurance Enrollment/Change Request Form

Name \_\_\_\_\_ Personal Email Address \_\_\_\_\_

Address \_\_\_\_\_

Phone Numbers (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_

### Level of Coverage (Choose One)

Single  Employee/Spouse  Employee/Child(ren)  Family

### List yourself and all eligible dependents to be covered under the plan(s):

Employee \_\_\_\_\_

Date of Birth \_\_\_\_\_

Add  Term

Social Security Number \_\_\_\_\_

Male  Female

Spouse \_\_\_\_\_

Date of Birth \_\_\_\_\_

Add  Term

Social Security Number \_\_\_\_\_

Male  Female

Child \_\_\_\_\_

Date of Birth \_\_\_\_\_

Add  Term

Social Security Number \_\_\_\_\_

Male  Female

Child \_\_\_\_\_

Date of Birth \_\_\_\_\_

Add  Term

Social Security Number \_\_\_\_\_

Male  Female

Child \_\_\_\_\_

Date of Birth \_\_\_\_\_

Add  Term

Social Security Number \_\_\_\_\_

Male  Female

### Medical Coverage Election (Choose One)

Medical PPO-A  Medical PPO-B

Please provide the following information if you and/or your eligible dependents are enrolled under Part A and/or Part B of Medicare, or if you have any other health plan coverage:  No  Yes (if yes, you must fill out the following information)

Employee: Part A  Part B  Other Coverage  ID # \_\_\_\_\_

Dependent: Part A  Part B  Other Coverage  ID # \_\_\_\_\_ Dependent Name \_\_\_\_\_

### Dental Coverage Election (Choose One)

Standard Dental  HMO Dental (Must choose dentist and list below for HMO Dental Only)

Dentist Name/phone #: 1<sup>st</sup> choice \_\_\_\_\_ 2<sup>nd</sup> choice \_\_\_\_\_

### Prescription and Vision Coverage (Eligible Employees Automatically Enrolled)

I represent that all information supplied in this application is true and complete. I understand that including any false or misleading information on an Enrollment/Change request form for a health benefit plan is subject to criminal and civil penalties. I authorize deductions from my earnings for any contributions required from me.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

OFFICE USE ONLY: Employment Date \_\_\_\_\_ Coverage Effective Date \_\_\_\_\_ System Input Date \_\_\_\_\_ Initial \_\_\_\_\_