Toms River Board of Education Medical Application

Name:		Home Phone #
Address:	City, State, Zip	Work Phone #
Indicate whether you and/or dependents, if any, are enrolled under Part A and/or B of Medicare	Applicant Part A B ID#_____ Dependent Part A B ID#_____ Name	
Type of Coverage: Single Husband/Wife Employee/Child Family		Marital Status Single Widowed Divorced Separated Married
Are you, your spouse or any dependent covered under another group Yes No If yes		Spouse's SS#
Provide name of Policyholder Last/First		
Policy or Identification #	Insurance Co Name & Address	Name and Address of Spouse's Employer

List all persons to be enrolled or affected by a change
I wish to enroll in the [ ] PPO-A [ ] PPO-B

Complete this section only if you are selecting the **POS Plan.** Note: You must select a Primary Care Physician **and an Alternate** in the event your first is not available.

First/Last Name	Sex	Date of Birth	Physician or Health Care Ctr.	J Code	Existing Patient Yes	Existing Patient No
Employee SS#	M F					
Spouse SS#	M F					
Child SS#	M F					
Child SS#	M F					
Child SS#	M F					
Child SS#	M F					
Child SS#	M F					

Dental Information	I wish to enroll in the: [ ] Standard [ ] DeltaCare (Flagship) **For DeltaCare Choose Dentist Below**	
	Dentist	Office Number
First Choice		
Second Choice		
Employee Signature:		**Date**:

OPEN ENROLLMENT 7/1/11

[ ] MEDICAL CHANGE **[ ] DENTAL CHANGE**