



TOMS RIVER BOARD OF EDUCATION

MEDICAL INSURANCE APPLICATION

Name: _____ Personal Email address: _____
 Address: _____
 Phone Numbers: (home) _____ (cell) _____

Please indicate whether you and/or your dependants, if any, are enrolled under Part A and/or Part B of Medicare:

No Yes If Yes, fill out the following:

Applicant Part A B ID# _____

Dependent Part A B ID# _____

TYPE OF MEDICAL COVERAGE

Choose One: Single Husband/Wife Employee/Child Family

Choose One: PPOA PPOB

List all persons to be enrolled or affected by a change:

Employee: _____ SEX: M F
 SS#: _____ DOB: _____

Spouse: _____ SEX: M F
 SS#: _____ DOB: _____

Child: _____ SEX: M F
 SS#: _____ DOB: _____

Child: _____ SEX: M F
 SS#: _____ DOB: _____

Child: _____ SEX: M F
 SS#: _____ DOB: _____

Child: _____ SEX: M F
 SS#: _____ DOB: _____

TYPE OF DENTAL COVERAGE

Standard Plan

Delta Care (add information below for Delta Care only)

Name and phone number for first choice for dentist: _____

Name and phone number for second choice for dentist: _____

Employee Signature: _____ **Date:** _____

FOR OFFICE USE ONLY:

Effective Date: _____ Date of Employment: _____ Cobra