TOMS RIVER REGIONAL SCHOOLS

1144 Hooper Avenue
Toms River, NJ 08753

Health Insurance Enrollment/Change Request Form

Name____ Phone Number _________________________________

Address____

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____ Social Security Number___________________________
Date of Birth_______________________ ☐ Male ☐ Female
Add ☐ Remove ☐

Spouse____ Social Security Number___________________________
Date of Birth_______________________ ☐ Male ☐ Female
Add ☐ Remove ☐

Child____ Social Security Number___________________________
Date of Birth_______________________ ☐ Male ☐ Female
Add ☐ Remove ☐

Child____ Social Security Number___________________________
Date of Birth_______________________ ☐ Male ☐ Female
Add ☐ Remove ☐

Child____ Social Security Number___________________________
Date of Birth_______________________ ☐ Male ☐ Female
Add ☐ Remove ☐

Medical Coverage Election (Choose One)

***Note: Employees hired 7/1/2020 and after are only eligible for the TRS EHP.**

☐ Medical PPO-A ☐ Medical PPO-B ☐ TRS EHP

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 #: 1st choice _______________________________ 2nd 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____

Rev: 01/2021