



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)

Medical PPO-A Medical PPO-B TRS EHP TRS GSP

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 (Choose One)

Standard Dental Fixed Copay PPO

Prescription and Vision Coverage (Eligible Employees Automatically Enrolled)

I represent all information supplied in this application is true and complete. I understand that including any false and 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 _____