Southern New Jersey Regional Employee Benefits Fund

c/o PERMA, TRIAD1828 CENTRE, P.O. BOX 99106, CAMDEN, NJ 08101

Employee/Participant Information (Retiree)

Please **PRINT** and fill this section out **COMPLETELY**

OPEN ENROLLMENT FORM

Social Security #:	Last Name:	First Name:	M.I.:
Gender: ☐ Male ☐ Female	Date of Birth:	Address:	
City:	State:	Zip:	Home Phone #:	Work Phone #:
E-mail:	PCP # (if required):	Division (if any):	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed			

Dependent Information (Spouse, Child or Children)

Please **PRINT** and fill this section out **COMPLETELY**

Please list all <u>eligible</u> dependents only.

Spouse

Social Security #:	First Name:	Last Name:	M.I.:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	

Child(ren)

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	
Full-Time Student? ☐ Yes ☐ No			

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	
Full-Time Student? ☐ Yes ☐ No			

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	
Full-Time Student? ☐ Yes ☐ No			

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	
Full-Time Student? ☐ Yes ☐ No			

Employer

Former Employer Name: Camden County Board of Social Services

Action to be Taken:

☐ New Enrollment – Effective Date: _________________

☐ Enrollment Change – Effective Date: _________________

Benefit Elections

Medical Coverage (prescription coverage is included)

☐ **Aetna HMO** ☐ **Aetna ACPOS II $10** ☐ **Aetna ACPOS II $15** ☐ **Aetna ACPOS II $15 / $25**

☐ **Aetna ACPOS II $20 / $30**

☐ **Amerihealth HMO** ☐ **Amerihealth PPO $10** ☐ **Amerihealth PPO $15** ☐ **Amerihealth PPO $15 / $25**

☐ **Amerihealth PPO $20 / $30**

Type of Coverage: ☐ Single ☐ Family ☐ Husband/Wife ☐ Parent/Child(ren)

☐ I elect not to enroll in any medical/ prescription plan ☐ I wish to cancel my medical / prescription coverage

Prescription Drug Coverage (if enrolling in prescription drug coverage only)

☐ **Express Scripts $7/$15$/30**

Type of Coverage: ☐ Single ☐ Family ☐ Husband/Wife ☐ Parent/Child(ren)

Dental

☐ **Delta Dental PPO**

Type of Coverage: ☐ Single ☐ Family ☐ Husband/Wife ☐ Parent/Child(ren)

☐ I wish to cancel my dental coverage ☐ I elect not to enroll in any dental plan

Type of Activity	
☐ **Open Enrollment**	**Date:** _____

Addition of Dependent

☐ Marriage ☐ Civil Union ☐ Birth ☐ Adoption/Guardianship/Foster Care

Add Coverage: ☐ Medical ☐ Rx ☐ Dental

Deletion of Dependent

☐ Divorce ☐ Death of spouse or child ☐ Child over age limit/ineligible

Remove Coverage: ☐ Medical ☐ Rx ☐ Dental

Employee Certification

I certify that all of the information supplied on this form is true to the best of my knowledge. I understand if I waive my right to coverage at this time, enrollment is not permissible until the next scheduled open enrollment. I understand that there is no guarantee of continuous participation by medical service providers, doctors or facilities in the Plans. If either my physician or medical center terminates participation in the Plan, I must select another doctor or medical center participating in the same plan. I authorize any hospital, physician or health care provider to furnish my medical plan or its assignee with such medical information about myself or my covered dependents as the medical plans or assignee may require.

Print Name: _____ Retiree Signature: _____

Date: _____