

Branchburg Township Board of Education Prescription Enrollment Form Instructions

CLIENT INFORMATION: (complete)

Client Name: **Branchburg Township Bd of Ed**, Client #: **1222**, Group # **Leave Blank**. (We will complete based on medical plan selected).

CARDMEMBER INFORMATION: (complete)

First Name, MI, Last Name, Skip ID#, SS#, Mailing Address, City, State, Zip Code, Phone Number, Cell Number and Email.

COVERAGE TYPE: (complete)

Please check one:

Single (you are only covering yourself)

CardMember/Child (you plus one child)

CardMember/Spouse (you plus a spouse/civil union partner)

CardMember/Children (you plus more than one child)

Family (you plus a spouse/civil union partner & a child or children)

Effective Date: Insert in box **7/1/2016**

REASON CODE: (complete)

A - New Enrollment to be used in the Eligibility Section below.

ELIGIBILITY: (complete)

Complete the CardMember line for yourself, 02 spouse for your spouse and children starting at 03. It is not necessary to complete **Email/Phone** for your dependents. Complete **Last Name, First Name, MI, Gender, Birthdate, SSN**, skip **HICN** and place **A** in the **Reason Code**. On the **Back of Enrollment Form** place the address of any dependent's that differs from that of the employee.

COORDINATION OF BENEFITS: (complete)

If you have other prescription coverage aside from the coverage at Branchburg Township Bd of Ed please place this information in this area. If Branchburg is your only prescription coverage simply place **N/A** in this area.

SIGNATURES: (complete)

Please Sign Your Name above Member Signature

****Very Important Do Not Forget****

Forms Should Be Handed In As Soon As Possible But No Later Than 1 Week After Your Meeting