North Brunswick Township Board of Education
Benefit Enrollment Form

Please complete this form if you wish to enroll or terminate in benefit coverage, switch plans during open enrollment, or enroll/remove a dependent.

Employee Information - PLEASE PRINT CLEARLY

_____ Last Name, First Name

_____ Employee Social Security Number

_____ Home Mailing Address, City, State & Zip Code

_____ Employee Hire Date

_____ Plan Start Date

Individuals Covered - PLEASE PRINT CLEARLY

	Enroll/Remove		Name (Last Name, First Name)	Male/Female		Date of Birth	Social Security Number	Please Select: Medical	RX	Dental
Employee	☐	☐		☐	☐			☐	☐	☐
Spouse	☐	☐		☐	☐			☐	☐	☐
Child	☐	☐		☐	☐			☐	☐	☐
Child	☐	☐		☐	☐			☐	☐	☐
Child	☐	☐		☐	☐			☐	☐	☐
Child	☐	☐		☐	☐			☐	☐	☐

Select Medical/Prescription Plan: There is only one plan available for dental coverage; this is through Delta Dental.

☐ Aetna NJEHP ☐ Aetna Garden State ☐ Aetna Chp 78 **(Only for those hired prior to 7/1/2020)**

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 also attest that the dependents listed here (if applicable) meet the dependent eligibility criteria of the Plan. I understand that in the event I cover any dependent that does not meet the eligibility provisions of the Plan that doing so shall invalidate their coverage and potentially my coverage and that I may be subject to penalties.

Employee Signature: _____ Date: _____