Mercer County SPECIAL SERVICES School District

Enrollment Form / Payroll Authorization

Employees Hired On/After 7/1/2020

EMPLOYEE INFORMATION

Please provide all requested information.

Last Name:	First Name:	M.I.:	Social Security Number	Marital Status: ☐ Single ☐ Married ☐ Divorced	
Address:			Date of Birth:	Gender:	Date of Hire:
City:		State:	Zip:		Home Phone Number:
Department:					

TYPE OF ENROLLMENT

☐ New Hire - Effective Date: _____	☐ Open Enrollment - Effective Date: _____	☐ Life Event - Effective Date: _____

IMPORTANT! Proof of a life event is required! Please provide documentation (e.g. a marriage certificate, divorce decree, birth certificate, adoption paperwork, etc.) to Human Resources within 60 days of your life event or coverage will be affected.

MEDICAL COVERAGE OPTIONS

Please check (✓) one box.

	Single	Parent/Child	EE + Spouse	Family	Waive
Horizon Educators Health Plan (NJEHP)	☐	☐	☐	☐	☐
Horizon Garden State Health Plan (GSP)	☐	☐	☐	☐	☐

PRESCRIPTION COVERAGE OPTIONS

Please check (✓) one box.

	Single	Parent/Child	EE + Spouse	Family	Waive
Benecard (NJEHP)	☐	☐	☐	☐	☐
Benecard (GSP)	☐	☐	☐	☐	☐

PLEASE NOTE: You will be automatically enrolled in prescription coverage based on your medical plan election. For example, if you elected to enroll in the NJEHP medical plan you will automatically be enrolled in the Benecard NJEHP prescription plan.

DENTAL COVERAGE OPTIONS

Please check (✓) one box.

	Single	Parent/Child	EE + Spouse	Family	Dentist Office ID Number Required if selecting the Dental Choice Plan	Waive
Horizon Dental Option Plan	☐	☐	☐	☐	N/A	☐
Horizon Dental Choice Plan	☐	☐	☐	☐		☐

DEPENDENT INFORMATION *					Please provide all requested information and check (✓) all boxes that apply.
Dependent's First Name, Middle Initial & Last Name	**Relationship** SP = Spouse CU = Civil Union C = Child	**Date of Birth** (MM/DD/YY)	**Social Security Number**	**Gender** (M/F)	**Coverage**
					☐ Medical ☐ Prescription ☐ Dental
					☐ Medical ☐ Prescription ☐ Dental
					☐ Medical ☐ Prescription ☐ Dental
					☐ Medical ☐ Prescription ☐ Dental
					☐ Medical ☐ Prescription ☐ Dental

*** If enrolling more than five (5) dependents for coverage, please write all information on additional sheet of paper.**

Applicant Statement of Understanding

I hereby declare, under penalty of perjury, that the information that I provided on this form is accurate and complete, and if applicable, that the dependents that I am enrolling in coverage or opting out of coverage are my legal dependents and meet the definitions outlined in the plan documents.

If I am opting out myself or any of my dependents, I attest that I/we have alternative and comparable coverage from an alternative source for the upcoming plan year. I understand that if I lose this coverage during the upcoming plan year, that it is my responsibility to inform Mercer County Special Services School District within 60 days, so that I, or any of my eligible family members, may become covered under the Mercer County Special Services School District Plan. I understand that the Mercer County Special Services School District reserves the right to require proof of valid dependent eligibility status in conjunction with the operation of both its benefit and opt out programs and if I fail to provide the necessary required documentation, then the Mercer County Special Services School District will terminate coverage for these dependents. Further, I understand that I will be required to reimburse the Mercer County Special Services School District for all insurance premiums or opt out dollars paid if the Mercer County Special Services School District determines that my dependents were not eligible for coverage or if we did not have alternative and comparable coverage.

I understand that IRS §125 prohibits me from changing my enrollment during the Plan Year, unless I experience a qualifying life event. A qualifying event includes a marriage, divorce, death of a spouse/civil union partner or a dependent, birth or adoption of a child, termination, or commencement of employment for my spouse/civil union partner, a change in employment status (full-time to part-time or part-time to full-time) for me or my spouse/civil union partner that affects benefits eligibility, or taking an unpaid, medical leave of absence by either me or my spouse/civil union partner. If I experience one of these qualifying events, I understand that I am obligated to notify the Human Resources Department within 60 days and that failure to do so may affect benefits coverage.

My signature below indicates that I have read and understood this Enrollment & Authorization Form and the descriptive materials made available to me under the Mercer County Special Services School District Employee Benefits Program. I understand that if I elect medical, prescription drug, dental and/or vision benefits that require employee contributions, my employer will deduct this amount from my before-tax income. I also understand that this salary reduction authorization can only be changed during initial enrollment periods, unless I have a change in family status as defined by law. I certify that the information that I have provided on this form is complete and accurate to the best of my knowledge.

Employee Signature **Date**

For Human Resources Use Only:

Date Received: _____ Received by: _____ Benefits Effective Date: _____