2024-2025 Benefits Enrollment Form

INSERTS EAST

PLEASE PRINT NEATLY

First Name	Last Name	Date of Birth
Street Address Unit #	City State Zip Code	Benefit Eligibility Date
Social Security #		Date of Hire
Position	Department	Earnings per pay period
Pay Type: ☐ Hourly ☐ Salaried	Gender: ☐ Male ☐ Female	

Please mark your coverage choices carefully. If you are not electing to enroll in a plan, check the appropriate waiver of coverage box under that coverage type. ALL COSTS ARE PER PAY PERIOD (BI-WEEKLY). Your New Jersey registered civil union partner and their children will also be eligible to receive health and welfare benefits where available. There may be important personal tax consequences that arise as a result of civil union coverage. Before enrolling your civil union partner and his or her eligible children, you should talk to your tax advisor about the tax implications for you

ENROLL FOR COVERAGE

☐ New / Rehire
☐ Open Enrollment
☐ Non-Eligible to Eligible Status
☐ Loss of Other Coverage
Date of Loss: _____
☐ Other: _____

CHANGES TO COVERAGE

Add Dependents:
☐ Birth/Adoption ☐Marriage ☐Other (specify): _____

Date of Event: _____

Remove Dependents:
☐ Divorce/Separation ☐ Death ☐ Other (specify): _____

Date of Loss: _____

Other Changes: Name Change (SSN card required) ☐ Address Change ☐ Beneficiary Change

ALL COSTS ARE PER PAY PERIOD (BI-WEEKLY)

MEDICAL COVERAGE

COVERAGE LEVEL	Horizon BCBS HSA Plan	Horizon BCBS EPO Plan	Horizon BCBS Direct Access Plan
☐ Employee Only	☐ $108.00	☐ $305.00	☐ $365.00
☐ Employee + Spouse	☐ $360.00	☐ $495.00	☐ $610.00
☐ Employee + Child(ren)	☐ $330.00	☐ $450.00	☐ $550.00
☐ Family	☐ $410.00	☐ $645.00	☐ $800.00
☐ Civil Union Partner	☐ $360.00	☐ $495.00	☐ $610.00

I WAIVE medical coverage due to: ☐ Cost ☐ Spouse Coverage ☐ Coverage through government ☐ Other Coverage _____

VISION COVERAGE

COVERAGE LEVEL	
☐ Employee Only	☐ $2.72
☐ Employee + Spouse	☐ $4.90
☐ Employee + Child(ren)	☐ $4.36
☐ Family	☐ $7.08
☐ Civil Union Partner	☐ $4.90

I WAIVE vision coverage due to: ☐ Cost ☐ Spouse Coverage ☐ No need ☐ Coverage through government

DENTAL COVERAGE

COVERAGE LEVEL	
☐ Employee Only	☐ $12.12
☐ Employee + Spouse	☐ $23.99
☐ Employee + Child(ren)	☐ $30.22
☐ Family	☐ $42.09
☐ Civil Union Partner	☐ $23.99

I WAIVE dental coverage due to: ☐ Cost ☐ Spouse Coverage ☐ No need ☐ Coverage through government

DEPENDENT INFORMATION

DEPENDENT INFORMATION (Last Name, First Name M)	Relationship	Birthdate	Social Security Number	Gender	Student? Y/N
				☐ M ☐ F	☐ Y ☐ N
				☐ M ☐ F	☐ Y ☐ N
				☐ M ☐ F	☐ Y ☐ N

LIFE AND AD&D INSURANCE (COMPANY PAID)

Group Term Life Insurance Coverage Requested (Employee Only)	Benefits	Coverage Requested (Complete only if Plan provides a choice of Benefit Schedules)
Basic Term Life Insurance	☒	$10,000
Basic Accidental Death & Dismemberment (AD&D)	☒	$10,000

LIFE AND AD&D INSURANCE BENEFICIARY DESIGNATION

Please indicate your beneficiary designation for your Basic Life and AD&D Insurance benefits. You may indicate a Primary and Con- tingent Beneficiary. New enrollees need to submit their applications within 31 days. Evidence of insurability is required with applications submitted after 31 days or for more than the guaranteed issue amount.

Beneficiary Type	Beneficiary Name	Beneficiary Address	Date of Birth	SSN	Relationship	% of Benefit
Primary						
Contingent						

AUTHORIZATION

I acknowledge that the above represents my enrollment choices. I understand that by signing this form I am waiving or authorizing payroll deductions for any required contributions for the coverage(s) selected above. I understand that my pre-tax elections cannot be changed or cancelled during the plan year until a future open enrollment period or a qualified status change occurs. Further, I understand that if I am declining enrollment for myself or my eligible dependents including my spouse because of other insurance coverage, I may in the future be able to enroll myself or my dependents in the above plan(s) provided that I request enrollment within 30 days after my (our) coverage ends. If I do not enroll within 30 days of the loss of insurance coverage, my eligible dependents and I will not be permitted to enroll until the next Annual Enrollment period. In addition, if I have a change in status, I may be able to enroll myself and my dependents provided that I request enrollment within 30 days after the change in status effective date. I represent to the best of my knowledge and belief, all statements and answers entered into this application are true, complete and correct. I understand that omissions or misrepresentations with respect to the information provided may result in my coverage being void and that I will be responsible for reimbursement of all claims paid for myself or my dependents during an ineligible period.

Signature:_____ **Date:** _____