LINDEN BOARD OF EDUCATION
MEDICAL AND DENTAL ENROLLMENT

Aetna Group # 0169575-40-001 Delta Dental Group # 07757

A. EMPLOYEE INFORMATION

Last Name	First Name		M.I.
Social Security #	Date of Birth		M ☐ F ☐
Home Address	Apt.	City, State	Zip Code
Phone	E-mail		
Date of Hire			

B. PLAN OPTION

Educator Health Plan (EHP) Medical & Rx	☐ Single ☐ 2 Adults ☐ Parent/Child ☐ Family
Delta Dental PPO Plus Premier Plan	☐ Single ☐ 2 Adults ☐ Parent/Child ☐ Family
Waiving Coverage ***(please fill out and return the attached waiver)***	☐ Medical ☐ Dental

C. INDIVIDUALS COVERED *Identify individuals other than yourself for whom you are adding*
Employees who enroll dependents must submit eligibility verification in addition to this form.
(please see attached for more information on required documentation)

	Last Name, First Name	**Social Security #**	**Sex**	**Date of Birth** (MM/DD/YYYY)
SPOUSE			M☐ F☐	
CHILD			M☐ F☐	
CHILD			M☐ F☐	
CHILD			M☐ F☐	
CHILD			M☐ F☐	
CHILD			M☐ F☐	

Additional Dependents can be added on the back of this page

E. EMPLOYEE SIGNATURE

I represent that all the information supplied in this application is true and complete.

Signature: Date:

F. EMPLOYER VERIFICATION

The requested activity is believed eligible and is approved by the Employer.

Signature: Date:

Title: Benefits Coordinator S☐A☐D☐

Please return within 30 days of your employment date to: Taryn Ragonese-Carlson, Benefits Coordinator
Interoffice: Administrative Building or **email:** tragonese-carlson@lindenps.org

REQUIRED DOCUMENTATION FOR DEPENDENT ELIGIBILITY VERIFICATION & ENROLLMENT

The Linden Public School District is required to ensure that only employees and their eligible children, and eligible dependents are receiving health care coverage under the programs. As a result, the Linden Public Schools must guarantee consistent application of eligibility requirements within the plans. Employees who enroll children or dependents for coverage (spouses – same & opposite sex, civil union partners, children, disabled and/or over age children continuing coverage) must submit the following documentation in addition to the appropriate health benefits enrollment or change of status application.

DEPENDENTS	ELIGIBILITY DEFINITION	DOCUMENTATION REQUIRED
SPOUSE	A person to whom you are legally married.	• A photocopy of the Marriage Certificate **and** • A photocopy of the front page / top half of the employee's most recently filed federal tax return* (Form 1040) that includes the spouse.
CIVIL UNION PARTNER	A person of the same sex with whom you have entered into a civil union.	• A photocopy of the New Jersey Civil Union Certificate or a valid certification from another jurisdiction that recognizes same-sex civil unions **and** • A photocopy of the front page of the employee's most recently filed NJ tax return* that includes the partner **or** a photocopy of a recent (within 90 days of application) bank statement or bill that includes the names of both partner's and is received at the same address.
CHILDREN	A subscriber's child until age 26, regardless of the child's marital, student, or financial dependency status – even if the young adult no longer lives with his or her parents. This includes a stepchild, foster child, legally adopted child, or any child in a guardian-ward relationship upon submitting required supporting documentation.	• **Natural or Adopted Child** – A photocopy of the child's birth certificate showing the name of the employee as a parent. • **Step Child** – A photocopy of the child's birth certificate showing the name of the employee's spouse or partner as a parent **and** a photocopy of the marriage/partnership certificate showing the names of the employee and spouse/partner. • **Legal Guardian, Grandchild, or Foster Child** – Photocopies of Final Court Orders with the presiding judge's signature and seal. Documents must attest to the legal guardianship by the covered employee.
DEPENDENT CHILDREN WITH DISABILITIES	If a covered child is not capable of self-support when he or she reaches age 26 due to mental illness or incapacity, or a physical disability, the child may be eligible for a continuance of coverage. Coverage for children with disabilities may continue only while (1) you are covered under the Linden plans, and (2) the child continues to be disabled, and (3) the child is unmarried or does not enter into a civil union or domestic partnership, and (4) the child remains substantially dependent on you for support and maintenance. You will be contacted periodically to verify that the child remains eligible for continued coverage.	• Documentation for the appropriate "Child" type as noted on page 1 **and** a photocopy of the front page of the employee's most recently filed federal tax return* (Form 1040) that includes the child. • If Social Security disability has been awarded, or is currently pending, please include this information with the documentation that is submitted. **Please note** that this information is only verifying the child's eligibility as a dependent. The disability status of the child is determined through a separate process.

***Note:** For tax forms you may black out all financial information and all but the last 4 digits of any Social Security numbers.

To obtain copies of the documents listed above, contact the office of the Town Clerk in the city of the birth, marriage, etc., or visit these Web sites: **www.vitalrec.com** or **www.studentclearinghouse.org** New Jersey residents can obtain records from the State Bureau of Vital Statistics and Registration Web site: **www.state.nj.us/health/vital/index.shtml**

REQUIRED DOCUMENTATION FOR DEPENDENT ELIGIBILITY VERIFICATION & ENROLLMENT

The Linden Public School District is required to ensure that only employees and their eligible children, and eligible dependents are receiving health care coverage under the programs. As a result, the Linden Public Schools must guarantee consistent application of eligibility requirements within the plans. Employees who enroll children or dependents for coverage (spouses – same & opposite sex, civil union partners, children, disabled and/or over age children continuing coverage) must submit the following documentation in addition to the appropriate health benefits enrollment or change of status application.

DEPENDENTS	ELIGIBILITY DEFINITION	DOCUMENTATION REQUIRED
CONTINUED COVERAGE FOR OVER AGE CHILDREN	Certain children over age 26 may be eligible for continued coverage until age 31 under the provisions of Chapter 375, P.L. 2005. This includes a child by blood or law who: • Is under the age of 31; • Is unmarried or not a partner in a civil union or domestic partnership; • Has no dependent(s) of his or her own; • Is a resident of New Jersey or is a student at an accredited public or private institution of higher education, with at least 15 credit hours; and • Is not provided coverage as a subscriber, insured, enrollee, or covered person under a group or individual health benefits plan, church plan, or health benefits plan, or entitled to benefits under Medicare.	• Documentation for the appropriate "Child" type as noted on page 1 **and** a photocopy of the front page of the child's most recently filed federal tax return* (Form 1040), **and** if the child resides outside of the State of New Jersey, documentation of full time student status must be submitted.

***Note:** For tax forms you may black out all financial information and all but the last 4 digits of any Social Security numbers.

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PLEASE SUBMIT ALL REQUIRED DEPENDENT DOCUMENTATION WITH YOUR ENROLLMENT FORMS.

LINDEN BOARD OF EDUCATION

HEALTH COVERAGE WAIVER

Employee Name _____ Date of Hire _____

I acknowledge that I have been given the opportunity to enroll myself and eligible dependents in Linden Board of Education's group health insurance plan.

I DECLINE MEDICAL ☐ DENTAL ☐ ENROLLMENT AT THIS TIME BECAUSE:

☐ I am covered by my spouse's/domestic partner's coverage

Insurance Name/ID _____

☐ Other (please explain) _____

_____

_____

I understand that by waiving coverage I will not be able to enroll in this health plan until the next open enrollment, unless there is a qualified change in status. Examples include; if you are covered under another plan but that coverage is lost, or if you gain a new dependent through birth, adoption, or marriage. However, you must request to enroll in your plan within 30 days of the qualified change in status. If you miss the 30-day deadline, you must wait until open enrollment.

Employee Signature _____ Date _____