Newark Board of Education

Roger León, Superintendent

Please return completed form to:
Newark Board of Education
Human Resource Services-Benefit Services
765 Broad Street
Newark, NJ 07102
benefits@nps.k12.nj.us

Retiree Benefits Enrollment Form

EMPLOYEE INFORMATION			Please provide all requested information	
Last name: First Name:		Social Security Number:	Marital Status: ☐Single ☐Married ☐Divorced ☐Widow	
Address:		Date of Birth:	Gender: ☐ M ☐ F ☐U	Date of Retirement:
City: State: Zip:		Employee ID:		Home Phone Number:

Please check the box for your current Union:

☐ Local 3 ☐ Local 32 ☐ Local 68 ☐ Local 617 ☐ BTC ☐ CASA ☐ NTA ☐ NTU ☐ Unaffiliated

MEDICAL AND PRESCRIPTION COVERAGE	PLEASE CHECK (☑) ONE BOX				
	Single	**Parent / Child(ren)**	**EE + Spouse / Civil Union Partner**	**Family**	**PCP Office ID Number Required if selecting any of the HMO Plans**
New Jersey Educators Plan	☐	☐	☐	☐	N/A
I elect to waive medical coverage in any medical plan.					☐

AETNA DENTAL COVERAGE	PLEASE CHECK (☑) ONE BOX				
Aetna Dental Option*	**Single**	**Parent/Child(ren)**	**EE + Spouse / Civil Union Partner**	**Family**	**Waive**
DPPO (Open) ☐ **DMO** (Closed) ☐	☐	☐	☐	☐	☐

*Based on your union you will be enrolled in the corresponding dental group plan:
1) CASA & Unaffiliated Dental Group
2) BTC, Local 3, 32, 68, 617, & NTA Dental Group
3) NTU Dental Group

Disclaimer: An employee waiting on approval for the State's Disability Retirement can participate under the Newark Board of Education Private Retiree Plan. However, no refund will be issued if or when Disability Retirement is approved accordingly.

DEPENDENT INFORMATION	Please provide all requested information.				
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/U)	PCP Designation for Dependents enrolled in the HMO Plans

Name _____ Employee ID Number _____

DEPENDENT INFORMATION cont.	Please provide all requested information.				
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/U)	PCP Designation for Dependents enrolled in the HMO Plans

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.

I understand that the Newark Board of Education reserves the right to require proof of valid dependent eligibility status in conjunction with the operation of its benefit program and if I fail to provide the necessary required documentation, then the Newark Board of Education will terminate coverage for these dependents. Further, I understand that I will be required to reimburse the Newark Board of Education for all insurance premiums paid if the Newark Board of Education determines that my dependents were not eligible for 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 Resource Services – Benefits Services within 30 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 Newark Board of Education Retiree Benefits Program. I understand that if I elect medical and/or prescription drug, benefits I will be required to pay the retiree premiums on a monthly basis. I have provided on this form is complete and accurate to the best of my knowledge.

Retiree Signature_____ Date_____

For Office Use Only:

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