



Enrollment Form

TODAY'S DATE: _____

CLIENT INFORMATION

Delran Township Board of Education

1104 0111000-0113099; 0810100-0810199; 0911000-0911099

CLIENT NAME (PLAN SPONSOR/ EMPLOYER)

CLIENT #

GROUP #

CARDMEMBER INFORMATION

FIRST NAME

MI

LAST NAME

ID #

SSN#

MAILING ADDRESS

CITY

STATE

ZIP CODE

PHONE NUMBER

CELL PHONE

EMAIL

COVERAGE TYPE

PLEASE CHECK ONE:

SINGLE

CARDMEMBER/SPOUSE

CARDMEMBER/CHILD

CARDMEMBER/CHILDREN

FAMILY

EFFECTIVE DATE: _____

REASON CODE

A	NEW ENROLLMENT
B	REINSTATE MEMBER
C	REINSTATE DEPENDENT / SPOUSE
D	ADD DEPENDENT / SPOUSE
E	TERMINATE COVERAGE
F	TERMINATE DEPENDENT COVERAGE
G	NAME CHANGE
H	ADDRESS CHANGE
I	GROUP CHANGE: FROM _____ TO _____

J	RDS ENROLLMENT, APPLICATION NUMBER IF APPLICABLE: _____
K	ISSUE CARD
L	DO NOT ISSUE ID CARD
M	COBRA ENROLLMENT
N	COBRA TERMINATION
O	STUDENT STATUS UPDATE
P	DISABLED DEPENDENT
Q	OVERAGE DEPENDENT**
R	DEPENDENT ADDRESS DIFFERS FROM CARDMEMBER (INCLUDE ON BACK)

ELIGIBILITY

	LAST NAME	FIRST NAME	MI	GENDER	BIRTHDATE	SSN	HICN	REASON CODES
CARDMEMBER								
02 SPOUSE								
EMAIL/PHONE*								
03 DEPENDENT								
EMAIL/PHONE*								
04 DEPENDENT								
EMAIL/PHONE*								
05 DEPENDENT								
EMAIL/PHONE*								
06 DEPENDENT								
EMAIL/PHONE*								
07 DEPENDENT								
EMAIL/PHONE*								
08 DEPENDENT								
EMAIL/PHONE*								

*OPTIONAL, ONLY IF DIFFERENT FROM CARMEMBER

COORDINATION OF BENEFITS

SECONDARY COVERAGE ID NUMBER

INSURANCE COMPANY

POLICY / GROUP#

EMPLOYER/PLAN SPONSOR

EFFECTIVE DATE

SIGNATURES

MEMBER SIGNATURE

CLIENT SIGNATURE

FOR INTERNAL USE ONLY:

DATE ENTERED: _____

ENTERED BY: _____

LOGGED BY: _____

Back of Enrollment Form

Dependent Address (1)
(if differs from cardmember)

FIRST NAME MI LAST NAME ID # SSN
MAILING ADDRESS CITY STATE ZIP CODE
PHONE NUMBER CELL PHONE EMAIL

Dependent Address (2)
(if differs from cardmember)

FIRST NAME MI LAST NAME ID # SSN
MAILING ADDRESS CITY STATE ZIP CODE
PHONE NUMBER CELL PHONE EMAIL

Dependent Address (3)
(if differs from cardmember)

FIRST NAME MI LAST NAME ID # SSN
MAILING ADDRESS CITY STATE ZIP CODE
PHONE NUMBER CELL PHONE EMAIL

Dependent Address (4)
(if differs from cardmember)

FIRST NAME MI LAST NAME ID # SSN
MAILING ADDRESS CITY STATE ZIP CODE
PHONE NUMBER CELL PHONE EMAIL

Dependent Address (5)
(if differs from cardmember)

FIRST NAME MI LAST NAME ID # SSN
MAILING ADDRESS CITY STATE ZIP CODE
PHONE NUMBER CELL PHONE EMAIL

Delran Township Board of Education

Client ID# 1104 Group #: 0111000-0113099

Your Co-Payment Schedule

Retail:

- \$10 for a Generic Equivalent Medication
- \$20 for a Brand Name Medication

Mail Order:

- \$20 for a Generic Equivalent Medication
- \$40 for a Brand Name Medication

Client ID# 1104 Group #: 0810100-0810199 (Administrative Staff Only)

Your Co-Payment Schedule

Retail:

- \$1 for a Generic Equivalent Medication
- \$1 for a Brand Name Medication

Mail Order:

- \$0 for a Generic Equivalent Medication
- \$0 for a Brand Name Medication

Client ID# 1104 Group #: 0810100-0810199 (NJ Educators Health Plan)

Your Co-Payment Schedule

Retail:

- \$5 for a Generic Equivalent Medication
- \$10 for a Brand Name Medication

Mail Order:

- \$10 for a Generic Equivalent Medication
- \$20 for a Brand Name Medication

Client ID# 1104 Group #: 0921000, 0921098, 0921099 (GSP)

Your Co-Payment Schedule

Retail:

- \$5 for a Generic Equivalent Medication
- \$10 for a Brand Name Medication

Mail Order:

- \$10 for a Generic Equivalent Medication
- \$20 for a Brand Name Medication