Horizon

Horizon Blue Cross Blue Shield of New Jersey

GROUP ENROLLMENT/CHANGE REQUEST

Mail to: Horizon BCBSNJ
Attn: Large and Mid-Size Group Enrollment
P.O. Box 10168
Newark, NJ 07101-3168
Email to: Midmajor_enrollment@horizonblue.com
Fax to: (973) 274-2297
HorizonBlue.com

Group Information to be completed by Employer.

Group Name: Cherry Hill Township Group Number: 08516R

Sub Group Number: _____ Date of Hire: ____/____/_____ Effective Date/Date of Event: ____/____/_____

Reason: _____

A. Type of Activity to be completed by Employer.

Refer to instructions before completing this form. Print clearly.

☐ ADD ☐ REMOVE ☐ OTHER CHANGE	Effective Date	Reason for Change
☐ Subscriber	_____/_____/_____	_____
☐ Spouse	_____/_____/_____	_____
☐ Civil Union Partner (CUP)	_____/_____/_____	_____
☐ Domestic Partner (DP)	_____/_____/_____	_____
☐ Dependent Child	_____/_____/_____	_____
☐ Over-Age Child as a Dependent Under 31 *(and complete Coverage Continuation section)*	_____/_____/_____	_____
☐ Name Change	_____/_____/_____	_____
☐ Change Plan	_____/_____/_____	_____
☐ Other	_____/_____/_____	_____
☐ Add/Change Office ID Numbers: Primary Care Provider	_____/_____/_____	_____

COVERAGE CONTINUATION

☐ **For Employee** Billing: Group

Date of Loss of Coverage | Qualifying Event #** | Date of Qualifying Event

_____/_____/_____ _____ _____/_____/_____

☐ Total Disability* ☐ COBRA/NJSGC Length of Continuation (in months): ☐ 18 ☐ 29 **Attach proof of disability*

☐ **For Spouse/Civil Union Partner*/Domestic Partner** Billing: Group

Date of Loss of Coverage | Qualifying Event #** | Date of Qualifying Event

_____/_____/_____ _____ _____/_____/_____

☐ COBRA/NJSGC Length of Continuation (in months): ☐ 18 ☐ 29 ☐ 36

**Civil union partners are eligible to make an election pursuant to NJSGC, if applicable.*

☐ **For Dependent or Over-aged Child**

☐ COBRA/NJSGC Length of Continuation (in months): ☐ 18 ☐ 29 ☐ 36 Billing: Group

Date of Loss of Coverage | Qualifying Event #** | Date of Qualifying Event

_____/_____/_____ _____ _____/_____/_____

☐ Dependent Under 31 Billing: Home

Date of Loss of Coverage | Qualifying Event #** | Date of Qualifying Even

_____/_____/_____ _____ _____/_____/_____

Home Address: _____

***Qualifying event #s: see list in Instructions.*

B. Employee Information – to be completed by Employee.

☐ **ADD** ☐ **REMOVE** ☐ **CONTINUATION** ☐ **OTHER CHANGE**

If a name change, indicate prior name: _____

Last Name, First Name, M.I. _____

Social Security # _____ Date of Birth _____/_____/_____ Sex _____

Home Address _____ Apt. _____ City _____ State _____ Zip Code _____

Home Phone _____ E-Mail Address _____

Employer Name _____ Employment Date _____/_____/_____

Employer Address _____ City _____ State _____ Zip Code _____

Hours Worked Per Week _____ Work Phone _____ E-Mail Address _____

Primary Care Provider Name _____ Current Patient ☐ Yes ☐ No

NPI # _____ Loc Code _____

Other Health Coverage ☐ Yes ☐ No, If Yes, Payer Name _____

Policy # _____ Medicare ID #, If any _____

The Employee Copy of this application may be used as a temporary ID card for thirty days from the effective date if authorized by Employer. Coverage must be verified with Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc. prior to visiting a physician or admission to a hospital.

C. Race/Ethnicity – to be completed by the Employee, at his/her option.

NOTE: Your response is appreciated but NOT required! *Choose a category that most closely describes you:*

☐ American Indian or Alaskan Native ☐ Black, not of Hispanic origin
☐ Hispanic ☐ Asian or Pacific Islander ☐ White, not of Hispanic origin

D. Plan Option – to be completed by the Employee. Your selection must be offered by your employer

Active Medical/Rx: ☐ S ☐ F ☐ 2 Adults ☐ Parent/Child(ren)

☐ Horizon Direct Access Design 8 (No Deductible) **UNION EMPLOYEES ONLY**

☐ Horizon Direct Access Design 8 (With Deductible - 2019) **UNION EMPLOYEES ONLY**

☐ Horizon Direct Access Design 7 (Union Silver -20/30)

☐ Horizon POS-1 (New NC Silver Plan - PCP required)

☐ Omnia State Defector (w BlueCard)

☐ Horizon State Defector HSA (High Deductible)

Retiree Medical/Rx: ☐ Single ☐ Family ☐ 2 Adults ☐ Parent/Child(ren)

☐ Horizon Direct Access Design 8 U65 Retiree (No Deductible)

☐ Horizon Direct Access Design 7 U65 Retiree

☐ Horizon State Defector HSA U65 Retiree

☐ OMNIA State Defector w/BlueCard U65 Retiree

☐ Horizon POS-1 (New NC Silver Plan - PCP required)

E. Other Individuals Covered – to be completed by Employee.

Identify individuals other than yourself for whom you are adding/changing/removing/continuing coverage. Attach additional pages if necessary, with your signature and dated. Attach proof of disability.

1. SPOUSE/CUP/DP ☐ ADD ☐ REMOVE ☐ CONTINUE SPOUSE (COBRA/NJSGC) ☐ CONTINUE CU PARTNER (NJSGC) ☐ CONTINUE DP (COBRA/NJSGC) ☐ OTHER CHANGE

Last Name, First Name, M.I. _____

Social Security # _____ Date of Birth _____/_____/_____ Sex _____

Primary Care Provider Name _____ Current Patient ☐ Yes ☐ No

NPI# _____ Loc Code _____

Other Health Coverage ☐ Yes ☐ No, If Yes, Payer Name _____

Policy # _____ Medicare ID #, If any _____

Home or billing address same as Employee? ☐ Yes ☐ No *If No, Complete Section F2*

2. Child ☐ ADD ☐ REMOVE ☐ CONTINUATION ☐ OTHER CHANGE

Last Name, First Name, M.I. _____

Social Security # _____ Date of Birth _____/_____/_____ Sex _____

Primary Care Provider Name _____ Current Patient ☐ Yes ☐ No

NPI# _____ Loc Code _____

Other Health Coverage ☐ Yes ☐ No, If Yes, Payer Name _____

Policy # _____ Medicare ID #, If any _____

If last name is different from Employee's, please explain: _____

Living with Employee? ☐ Yes ☐ No *If No, Complete Section G*

3. Child ☐ ADD ☐ REMOVE ☐ CONTINUATION ☐ OTHER CHANGE

Last Name, First Name, M.I. _____

Social Security # _____ Date of Birth _____/_____/_____ Sex _____

Primary Care Provider Name _____ Current Patient ☐ Yes ☐ No

NPI# _____ Loc Code _____

Other Health Coverage ☐ Yes ☐ No, If Yes, Payer Name _____

Policy # _____ Medicare ID #, If any _____

If last name is different from Employee's, please explain: _____

Living with Employee? ☐ Yes ☐ No *If No, Complete Section G*

F. Additional Spouse/CUP/DP Information – to be completed by Employee. *If not applicable mark as N/A.*

1. Employer Name _____ Employer Phone _____

   Employer Address _____

   City _____ State _____ Zip Code _____

2a. Home Address _____ Apt _____

   City _____ State _____ Zip Code _____

2b. Please explain why the address is different: _____

G. Additional Child Information – to be completed by Employee.

Provide information below about children listed in Section E, if they have a different address from the employee. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.

Name _____

Address _____ Apt _____

City _____ State _____ Zip Code _____

Reason: _____

Name _____

Address _____ Apt _____

City _____ State _____ Zip Code _____

Reason: _____

H. Employee Signature

I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I authorize deductions from my earnings for any contributions required from me.

Signature: _____ Date: _____/_____/_____

I. Over-Age Child's Signature

I represent that all the information supplied in this application regarding the Dependent Under 31 Continuation Election is true and complete.
I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form.
I hereby agree to make premium payments required from me for the Dependent Under 31 Continuation Election.

Signature: _____ Date: _____/_____/_____

J. Employer Verification

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

Employer Representative: _____ Date: _____/_____/_____

Representative's Title: _____

Instructions

Employers

You must complete the Group Information and sections A and J in order for this application to be processed.

Employees

You must complete sections B through I and submit the signature of each Over-Age Child for which a Dependent Under 31 Continuation Election is made in accordance with Section J in order for this application to be processed.

- Please PRINT except when a signature is requested.
- If a dependent is disabled and you want to continue his or her coverage beyond age 26, you do not have to make a COBRA/NJSGC or Dependent Under 31 election. Instead, select "Other" in Section A, and attach proof of disability.
- Total Disability and COBRA are available continuation options under Vision coverage; Dependent Under 31 continuation is not available under Vision coverage.
- You can obtain the providers' correct names from the appropriate provider directory. You may also obtain each provider's NPI and LOC Code number from the provider directory or at: www.HorizonBlue.com. Providers with multiple office locations and individual providers who belong to more than one practice or provider entity may have more than one NPI number. You should confirm the correct NPI number for the specific provider and office location where you will be seen by contacting that office directly.

Qualifying Events

COBRA and NJSGC

C1. Termination of job or reduction in hours
C2. Employee enrollment in Medicare (COBRA only)
C3. Divorce (COBRA/NJSGC); civil union dissolution (NJSGC) if covered under group benefits
C4. Death of employee
C5. Loss of dependent child status under the plan.
C6. Disability (occurring subsequent to another qualifying event)

Dependent Under 31

D1. Loss of dependent status (aged out) and otherwise eligible
D2. Re-establish eligibility: residency
D3. Re-establish eligibility: nonresident full-time student
D4. Re-establish eligibility: change in marital status
D5. Re-establish eligibility: change in parental status
D6. Re-establish eligibility: termination of other coverage

Conditions of Enrollment - Applicant Acknowledgements and Agreements

On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer reporting agency, and any employer to give Horizon BCBSNJ[1], or any consumer reporting agency acting on behalf of Horizon BCBSNJ, information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that Horizon BCBSNJ has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one
4. I agree Horizon BCBSNJ will provide coverage in accordance with the terms of the contract for the group plan/policy.
5. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the group plan/policy if premiums are not paid timely. I authorize my Employer to withhold payments from my wages as contribution to the premium, as appropriate

Misrepresentations

Any person who includes any false or misleading information on an Enrollment/Change Request Form for a health benefits plan is subject to criminal and civil penalties.

Notices

General Notice of Special Enrollment Rights

If you are declining enrollment under your group health plan for yourself and/or your dependents (if your plan includes coverage for dependents) because of other health insurance or other group health plan coverage, you may be able to enroll yourself and those dependents in this group health plan if you or the dependents lose eligibility for that other coverage (or if the other employer or plan provider stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the other employer or plan provider stops contributing toward the other coverage).

In addition, if your plan includes coverage for dependents and you acquire a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents under this plan after declining its coverage. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

If you decline coverage under this plan, you may be asked to state in writing whether the declination was due to the existence of other health coverage. If this is so and you don't provide the statement, the above special enrollment rights may not be available to you if you need them.

To request special enrollment or obtain more information about it, contact your benefits department or personnel representative.

Notice on Dependent Under 31 Continuation

Horizon Blue Cross Blue Shield of New Jersey will bill over- age dependents directly
and enrollees will remit the premium directly to Horizon BCBSNJ. When Dependent Under 31 Continuation is selected, the home address must be completed under Section "A - Type of Activity" even when it is the same as the employee's address.

Important Note:

- Although the employee must continue eligibility under the dependent's plan for continued coverage of the dependent, in addition to the additional applicable eligibility criteria, coverage for the dependent will be issued as stand-alone coverage. All cost-sharing requirements and limitations will apply and will not be combined with the employee's policy. Consequently, covered expenses incurred by the over-age dependent will not contribute to family deductibles and out-of-pocket maximums, nor will family incurred expenses contribute to the over-age dependent's deductibles or out-of-pocket maximums.

Group Subscriber on behalf of itself and its participants hereby expressly acknowledges its understanding this
agreement constitutes a contract solely between Subscriber and Horizon BCBSNJ, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Horizon BCBSNJ to use the Blue Cross and Blue Shield Service Marks in the State of New Jersey, and that Horizon BCBSNJ is not contracting as the agent of the Association. Group Subscriber on behalf of itself and its participants further acknowledges and agrees that it has not entered into this agreement based upon representations by any person other than Horizon BCBSNJ and that no person, entity, or organization other than Horizon BCBSNJ shall be held accountable or liable to Group Subscriber for any of Horizon BCBSNJ's obligations to Group Subscriber created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of Horizon BCBSNJ other than those obligations created under other provisions of this agreement.

[1] Horizon BCBSNJ refers to Horizon Healthcare Services, Inc., doing business as Horizon Blue Cross Blue Shield Of New Jersey or any of its wholly owned subsidiaries including Horizon Insurance Company, Horizon Healthcare Dental, Inc., and Horizon Healthcare of New Jersey, Inc., doing business as Horizon NJ Health.

DELTA DENTAL

DENTAL ENROLLMENT FORM

(NON-CONTRACTUAL EMPLOYEES)

Group Number / Plan

- o **Premier** _____3202-0001
- o **Premier Buy-Up** _____3202-0005
- o **Preferred** _____3202-6001
- o **Preferred Buy-Up** _____3202-6005

Name of Employer	**Effective Date of Coverage**
Cherry Hill Township 820 Mercer Street Cherry Hill, NJ 08002	

GENERAL INFORMATION - THIS SECTION MUST BE COMPLETED - PLEASE PRINT CLEARLY

Name (Last) (First) (Middle)	**Date of Birth**	**Social Security Number**
	_____ / _____ / _____	___ ___ ___ - ___ ___ - ___ ___ ___ ___

Street Address	**City, State, Zip**	**County**

Date of Employment	**Type of Coverage**	**Marital Status**	**Email Address**
_____ / _____ / _____	o **Single** o **Parent/Child** o **Husband/Wife** o **Parent/Children** o **Family**	o **Single** o **Married** o **Divorced/Separated**	

Enrollment	**First Name - Last Name**	**Social Security Number**	**Date of Birth**	**Full-Time Student**
Subscriber		_____ - _____ - _____	/ /	
Spouse*		_____ - _____ - _____	/ /	
Dependent		_____ - _____ - _____	/ /	o **Yes** o **No**
Dependent		_____ - _____ - _____	/ /	o **Yes** o **No**
Dependent		_____ - _____ - _____	/ /	o **Yes** o **No**
Dependent		_____ - _____ - _____	/ /	o **Yes** o **No**

*** If spouse has other dental coverage, please list name and address of employer and other carrier:**

If choosing Flagship®, you must complete this section

	Choice of Dentist	**Office Number**	**For Delta Dental Use Only**
1	NOT REQUIRED		
2			
3			

Optional choices will be selected if a provider terminates his/her participation agreement with Flagship. I authorize the release to Flagship Dental Plans of all my treatment information as a DeltaCare® subscriber and the treatment information of my dependent(s). I understand that I may change my primary Plan Participating Dentist by calling or in writing provided that a request for such change is received by Flagship at least thirty (30) days prior to the new contract month. Request received by the tenth (10th) of the month will be effective the first (1st) of the following month.

I hereby represent that all information furnished is true and complete to the best of my knowledge and authorize my employer to make any required deduction from my wages.

_____ _____

Subscriber Signature **Date**

Delta Dental Use Only

_____

Entered

_____

Operator #

Participant Information

Employer Name: _____ **Employer/Location:** _____

Employee Name: _____ _____ _____
(First Name) (Middle Initial) (Last Name)

SSN/EEID: _____ **Date of Birth:** _____

Current Address: _____
(Street Address)

_____
(Floor or Apt No.)

_____
(City, State Zip)

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Married Filing Separately

Phone Number: _____ _____
(Cell Phone Number) (Home Phone Number)

Health Care Spending Account:

The Health Care Spending Account allows you to use pre-tax dollars to pay for expenses which are not 100% covered or are ineligible for payment through any group health care plan(s) under which you or your spouse are covered.

☐ **Yes, I want to participate**
☐ **No, I do not want to participate**

$ _____ ÷ _____ = $ _____

Plan Year Contribution Max of $2,550 | **# Pay Periods in the Plan Year** | **Pay Period Pre-Tax Contribution**

Dependent Care Spending Account:

The Dependent Care Spending Account allows you to use pre-tax dollars to pay for eligible dependent care expenses which enable you or your spouse (if applicable) to work or attend school on a full-time basis.

☐ **Yes, I want to participate**
☐ **No, I do not want to participate**

$ _____ ÷ _____ = $ _____

Plan Year Contribution Max of $7,500 ($3,750 if filing taxes separate) | **# Pay Periods in the Plan Year** | **Pay Period Pre-Tax Contribution**

I certify that I am not a sole proprietor, partner in a partnership or 2% or greater shareholder in an S-corporation.

I authorize the above elections and the subsequent adjustments to my base annual salary. I am aware that I have a grace period in which to submit reimbursement requests for expenses incurred during the plan year. Upon expiration of the grace period, any unused funds will be forfeited. I understand that my elections are binding for the entire plan year and cannot be altered, other than by my employer, unless I experience a status change and that I may experience future reductions in life, disability and Social Security benefits by participating in this Flexible Spending Plan.

PLEASE SUBMIT THIS COMPLETED FORM TO BENEFITS COORDINATOR. LATE ENROLLMENTS WILL NOT BE ACCEPTED.

Participant Signature _____ **Date** _____

Exhibit A

SALARY REDUCTION AGREEMENT
under the
CHERRY HILL TOWNSHIP FLEXIBLE BENEFIT PLAN
ELECTION/CHANGE FORM

To: Cherry Hill Township

Effective _____ (insert date salary reduction is to commence). I request my employer to reduce my taxable wages by the health insurance withholding amounts for the fiscal year. I understand that this total amount will be deducted pro-rata during each payroll period over the year. The amount of this total reduction shall be allocated to my spending accounts as follows (check the spending account desired):

☐ Health / Dental / Prescription Premium Conversion Spending Account. I request that my taxable wages each pay period be reduced by my share of any Health insurance premiums payable under any employer-sponsored health plan in which I am a participant and that my employer use the salary-reduced amounts to pay my share of the premiums. I understand that my salary reductions for this benefit will automatically change due to changes in the premium arrangements (e.g., an increase in premiums or an increase in the share of these premiums I may have to pay).

☐ Initial yearly election

☐ Revision Change in status (check one)

- ☐ Legal Marital-Marriage, Death of Spouse, Divorce, Legal Separation or Annulment.
- ☐ # of Dependents-Birth, Adoption or Death.
- ☐ Employment-Termination or commencement by Employee, Spouse or Dependent.
- ☐ Work Schedule-P/T, F/T, Strike, Reduction or increase in hours or unpaid leave.
- ☐ Change in Dependent's Status-Requirements for Coverage Due to Age, Student Status or Similar Circumstances.
- ☐ Residence or Worksite-Change for Employee, Spouse or Dependent.
- ☐ Cobra, Medicare or Medicaid
- ☐ Judgment, Decree or Order.
- ☐ Change in Cost of Coverage

☐ I do not wish to participate

I understand that this agreement is irrevocable except for certain changes specifically set forth in the plan documents. The amounts cannot be transferred from one account to another, carried over beyond the year to which this agreement relates or returned to me in cash or other remuneration. Failure to return this form will constitute a Default Election of Premium Conversion.

Dated: _____

_____ _____
Please print Employee's Name Employee Signature

For Administrator Use Only

Accepted on behalf of the Employer by: Dated: _____

_____
Signature of Employer
Authorized Representative

CHERRY HILL TOWNSHIP

WAIVER UNDER CAFETERIA PLAN OF PARTICIPATION

WHEREAS, in accordance with the cafeteria plan (the "Plan"), the Employee has elected to waive coverage for himself or herself and his or her eligible dependents of the health plans which the Employee would otherwise be entitled to receive, and

WHEREAS, such waiver is knowing and voluntary on the part of the Employee;

Please choose the following insurance plans to opt out:

☐ Health Insurance
☐ Dental Insurance
☐ Prescription Insurance

NOW, THEREFORE, in consideration of the promises contained herein, and subject to the provisions of the Plan, it is hereby agreed as follows:

l. Waiver of Participation in the selection of one or more above - In accordance with the Plan, the Employee, for himself or herself, his or her heirs, assigns, successors, spouse, and dependents hereby waives any right on his or her part of his or her part and the part of his or her spouse and dependents to participate in the benefits maintained by the Employer. In making this knowing and voluntary waiver, Employee on behalf of himself or herself, his or her spouse and dependents understands and agrees that they will have no coverage or benefits whatsoever under the selected plan(s) from above and that this waiver may not be revoked during the plan year, except to the extent permitted under the Plan in the event of a change in status or in the event of retirement.

2. Release and Indemnification - The Employee, for himself or herself, his or her heirs, assigns, successors, spouse and dependents covenants and agrees never to make a claim under the insurance plan(s) selected above and further fully releases the Employer, its officers, directors, employees and agents and insurance carriers from any liability arising in connection with any claim by the Employee, his or her heirs, assigns, successors, spouse and dependents for any benefits or coverage under the above selected plan(s), and the Employee, for himself or herself, his or her heirs, assigns, successors, spouse and dependents agrees to defend and indemnify the Employer, its officers, directors, employees and agents from any liability, loss, damages, costs or expenses (including, but not limited to, attorneys' fees) arising in connection with this Waiver or any claim for benefits or coverage under the above selected plan(s). The employee also agrees to sign any waiver required by the State Health Benefits Program Coverage.

3. Waiver Irrevocable During the Plan Year, Except Upon a Change in Status or in the Event of Retirement - Employee acknowledges and agrees that his or her decision to enter into this Waiver is knowing and voluntary, that he or she fully understands all the provisions of this Waiver and that this Waiver may be revoked during the plan year only to the extent permitted under the Plan in the event of a change in status or in the event of retirement.

The following events are considered a change in status:

1. Legal marital status - marriage, death of spouse, divorce, legal separation or annulment;
2. Number of dependents - birth, adoption, placement for adoption or death of a dependent;
3. Employment status - termination or commencement of employment by the employee, spouse or dependent;

4. Work schedule - including a switch between part-time and full-time, a strike or lockout, a reduction or increase in hours or unpaid leave of absence;
5. Change in dependent's status - a dependent satisfies or ceases to satisfy the requirements for coverage due to age, student status or similar circumstances;
6. Residence or worksite - a change in the place of residence or work of the employee, spouse or dependent.

The employee further acknowledges and agrees that he or she must notify Human Resources of any change in status within 30 days of the event causing the status change.

4. No Representations by Employer as to Possible Tax Consequences - Employer has made no representations to Employee with regard to the tax consequences of this Agreement and the Employer shall have no liability with regard to any such tax consequences.

5. Certification of Other Insurance - The Employee hereby certifies that he or she has existing and in effect other health and hospitalization insurance that provides coverage for himself or herself and for his or her eligible dependents.

6. Sealed Instrument - This Agreement shall constitute a sealed instrument under New Jersey law.

IN WITNESS WHEREOF, the Employee designated below has entered into this Waiver this _____, 20__.

The Employee

_____	_____	_____
(Signature)	Name (print)	Date

INSURANCE REBATE REQUEST

Full time employees who are eligible for Township health benefits may elect to receive a rebate if they waive medical/prescription and/or dental coverage. Rebate amounts are as follows:

MEDICAL	
Family	$2,000.00
Employee and Spouse	1,500.00
Parent and Child(ren)	1,200.00
Single	1,000.00
PRESCRIPTION	
Family	$ 435.00
Employee and Spouse	378.00
Parent and Child(ren)	274.00
Single	239.00
DENTAL	
Family	$ 184.00
Employee and Spouse	122.00
Parent and Child(ren)	122.00
Single	82.00

Eligibility requirements: Rebate eligibility criteria is the same as benefit eligibility criteria for health insurance purposes. The following requirements must be met:

- Spouses – Employee and spouse must be currently legally married and file taxes as married/jointly or married/separately.
- Children under the age of 2 do not qualify as dependents for dental rebate purposes.
- Children between the ages of 19 and 23 must be enrolled as full-time students to qualify as dependents for dental rebate purposes.
- Children over the age of 26 are not considered dependents for medical, dental, or prescription rebate purposes.

Employees must also complete a Waiver Under Cafeteria Plan of Participation Form and submit copies of applicable dependent verification documents (marriage cert., recent 1040 tax form, birth certs.).

INSURANCE REBATE REQUEST **NEW _____ UPDATE _____**
(check one)

EMPLOYEE: _____

I am waiving the health benefits checked below and would like to receive a health benefit rebate.

MEDICAL	**PRESCRIPTION**	**DENTAL**
___ Family	___ Family	___ Family
___ Employee/Spouse	___ Employee/Spouse	___ Employee/Spouse
___ Parent/Child	___ Parent/Child	___ Parent/Child
___ Single	___ Single	___ Single

Amount of rebate: $_____ / Annual, paid quarterly (pre-tax dollars)

Payment is made quarterly for the preceding three months.

By signing below, I certify that I have health insurance coverage currently effective with another health insurance policy/carrier. I also certify that I am eligible for the coverage that I have selected to waive and will notify the Human Resources Department immediately of any changes in my eligibility status.

_____ _____
Signature Date