

Southern New Jersey Regional Employee Benefits Fund

c/o PERMA, Po Box 99106, Camden, NJ 08101

Employee/Participant Information

Please **PRINT** and fill this section out **COMPLETELY**

ENROLLMENT FORM

Social Security #:	Last Name:	First Name:	M.I.:	
Gender: ☐ Male ☐ Female	Date of Birth:	Address:		
City:	State:	Zip:	Home Phone #:	Work Phone #:
E-mail:	PCP # (if required):	Division (if any):		
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed				

Dependent Information (Spouse, Child or Children)

Please **PRINT** and fill this section out **COMPLETELY**

Please list all eligible dependents only.

Spouse

Social Security #:	First Name:	Last Name:	M.I.:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	

Child(ren)

Social Security #:	First Name:	Last Name:	M.I.:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	

Full-Time Student? ☐ Yes ☐ No

Social Security #:	First Name:	Last Name:	M.I.:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	

Full-Time Student? ☐ Yes ☐ No

Social Security #:	First Name:	Last Name:	M.I.:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	

Full-Time Student? ☐ Yes ☐ No

Social Security #:	First Name:	Last Name:	M.I.:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	

Full-Time Student? ☐ Yes ☐ No

Action to be Taken:

☐ New Enrollment – Effective Date: _____

☐ Enrollment Change – Effective Date: _____

Benefit Elections

Medical Coverage

Carrier Name: Aetna

Plan Name: _____

Aetna Choice POS II \$15

Aetna Choice POS II \$15 (Deductible-2019)

Aetna Choice POS II \$20/\$20

Aetna Whole Health Plan OMNIA \$5/\$15

Aetna Choice POS II HDHP

Aetna QPOS \$5/\$5 *

Type of Coverage: ☐ EE Only ☐ EE + Child(ren) ☐ EE + Spouse ☐ EE + Family

☐ I elect not to enroll in any medical plan

☐ I wish to cancel my medical coverage

Prescription Drug Coverage

Carrier Name: Express Scripts

Plan Name: _____

Aetna Choice POS II \$15 (\$7/\$16/\$35)

Aetna Choice POS II \$15 (Deductible-2019) (\$7/\$16/\$35)

Aetna Choice POS II \$20/\$20 (\$3/\$18/\$46)

Aetna Whole Health Plan OMNIA \$5/\$15 (\$7/\$16/\$35)

Aetna QPOS \$5/\$5 (\$10/\$20/\$35) *

Type of Coverage: ☐ EE Only ☐ EE + Child(ren) ☐ EE + Spouse ☐ EE + Family

☐ I elect not to enroll in any prescription plan

☐ I wish to cancel my prescription coverage

Type of Activity

☐ Open Enrollment Date: _____ ☐ New Hire Date: _____ ☐ Termination Date: _____

Addition of Dependent

☐ Marriage ☐ Civil Union ☐ Birth ☐ Adoption/Guardianship/Foster Care

Add Coverage: ☐ Medical ☐ Rx ☐ Dental

Deletion of Dependent

☐ Divorce ☐ Death of spouse or child ☐ Child over age limit/ineligible

Remove Coverage: ☐ Medical ☐ Rx ☐ Dental

Employee Certification

I certify that all of the information supplied on this form is true to the best of my knowledge. I understand if I waive my right to coverage at this time, enrollment is not permissible until the next scheduled open enrollment. I understand that there is no guarantee of continuous participation by medical service providers, doctors or facilities in the Plans. If either my physician or medical center terminates participation in the Plan, I must select another doctor or medical center participating in the same plan. I authorize any hospital, physician or health care provider to furnish my medical plan or its assignee with such medical information about myself or my covered dependents as the medical plans or assignee may require.

Print Name: _____ Retiree Signature: _____

Date: _____

* Union Optional



DENTAL ENROLLMENT FORM (CONTRACTUAL EMPLOYEES)

Group Number / Plan

☐	Premier	_____ 3202-0001
☐	Preferred	_____ 3202-6001
☐	PPO Fixed Co-pay	_____ 3202-6007

Name of Employer

Cherry Hill Township
820 Mercer Street
Cherry Hill, NJ 08002

Effective Date of Coverage

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

____ / ____ / ____

☐ Single ☐ Parent/Child
☐ Husband/Wife ☐ Parent/Children
☐ Family

☐ Single
☐ Married
☐ Divorced/Separated

Enrollment

First Name - Last Name

Social Security Number

Date of Birth

Full-Time Student

Subscriber

_____ - _____ - _____

/ /

Spouse*

_____ - _____ - _____

/ /

Dependent

_____ - _____ - _____

/ /

☐ Yes ☐ No

Dependent

_____ - _____ - _____

/ /

☐ Yes ☐ No

Dependent

_____ - _____ - _____

/ /

☐ Yes ☐ No

Dependent

_____ - _____ - _____

/ /

☐ Yes ☐ No

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

I

Choice of Dentist

Office Number

For Delta Dental
Use Only

1

NOT REQUIRED

2

NOT REQUIRED

3

NOT REQUIRED

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 #

BENEFIT/OPTIONAL RATES - Calendar Year 2027

All Unions

F/T EMPLOYEES						
MEDICAL						
Effective 01/01/2027-6/30/2028			EE	ESP	PC	FAM
AETNA	Aetna Choice POS II \$15	GOLD	1,402.00	2,803.00	2,510.00	3,910.00
AETNA	Aetna Choice POS II \$15 (Deductible - 2019)	GOLD	1,395.00	2,789.00	2,496.00	3,890.00
AETNA	Aetna Choice POS II \$20/\$20	SILVER	1,367.00	2,734.00	2,447.00	3,814.00
AETNA	Aetna QPOS \$5/\$5	SILVER	1,160.00	2,319.00	2,076.00	3,141.00
AETNA	Aetna Whole Health Plan OMNIA \$5/\$15	BRONZE	1,115.00	2,229.00	1,995.00	3,109.00
AETNA	Aetna Choice POS II HDHP	BRONZE	1,115.00	2,229.00	1,995.00	3,109.00

*High deductible plan includes RX (combined)

**Optional

F/T EMPLOYEES						
PRESCRIPTION						
Effective 01/01/2027-6/30/2028			EE	ESP	PC	FAM
Express Scripts	Aetna Choice POS II \$7/\$16	GOLD	397.00	794.00	710.00	1,107.00
Express Scripts	Aetna Choice POS II \$7/\$16	GOLD	397.00	794.00	710.00	1,107.00
Express Scripts	Aetna Choice POS II \$3/\$18/\$46	SILVER	404.00	807.00	722.00	1,125.00
Express Scripts	RX \$10/\$20/\$35	SILVER	355.00	708.00	634.00	988.00
Express Scripts	Aetna Whole Health Plan OMNIA \$7/\$16/\$35	BRONZE	401.00	801.00	717.00	1,117.00

**Optional

F/T EMPLOYEES					
DENTAL					
Effective 01/01/2027 - 12/31/2027			EE	ESP/PC1	PC2/FAM
Delta Premier			32.36	55.53	102.46
Delta Preferred			29.68	50.26	90.57
Delta PPO Fixed Co-Pay Plan			37.97	73.74	123.52

*There is an additional monthly contribution when choosing the medical Gold plan. This amount is charged once per month in addition to your bi-weekly premium amount.

F/T EMPLOYEES						
MEDICAL - Monthly Buy-Up Contribution						
Effective 01/01/2027-6/30/2028			EE	ESP	PC	FAM
AETNA	Aetna Choice POS II \$15	GOLD	35.00	69.00	63.00	96.00
AETNA	Aetna Choice POS II \$15 (Deductible - 2019)	GOLD	28.00	55.00	49.00	76.00



State Health Benefits Program

PERCENTAGE OF PREMIUM CALCULATION CHARTS

For Health Benefit Contributions under P.L. 2011, c. 78

LOCAL GOVERNMENT EMPLOYEES

Annual Retirement Allowance Range	Single	Member/Spouse/Partner or Parent/Child	Family
Less than \$20,000	4.5%		
Less than \$25,000		3.5%	3%
\$20,000 - \$24,999.99	5.5%		
\$25,000 - \$29,999.99	7.5%	4.5%	4%
\$30,000 - \$34,999.99	10%	6%	5%
\$35,000 - \$39,999.99	11%	7%	6%
\$40,000 - \$44,999.99	12%	8%	7%
\$45,000 - \$49,999.99	14%	10%	9%
\$50,000 - \$54,999.99	20%	15%	12%
\$55,000 - \$59,999.99	23%	17%	14%
\$60,000 - \$64,999.99	27%	21%	17%
\$65,000 - \$69,999.99	29%	23%	19%
\$70,000 - \$74,999.99	32%	26%	22%
\$75,000 - \$79,999.99	33%	27%	23%
\$80,000 - \$84,999.99		28%	24%
\$80,000 - \$94,999.99	34%		
\$85,000 - \$89,999.99			26%
\$85,000 - \$99,999.99		30%	
\$90,000 - \$94,999.99			28%
\$95,000 and over	35%		
\$95,000 - \$99,999.99			29%
\$100,000 and over		35%	
\$100,000 - \$109,999.99			32%
\$110,000 and over			35%

Note: Member contribution is a minimum of 1.5% of base salary towards Health Benefits.

PERCENTAGE OF PREMIUM CALCULATION CHART
For Health Benefit Contributions under Chapter 78, P.L. 2011

Use this worksheet and the attached charts to calculate your combined Health Benefit Contribution.

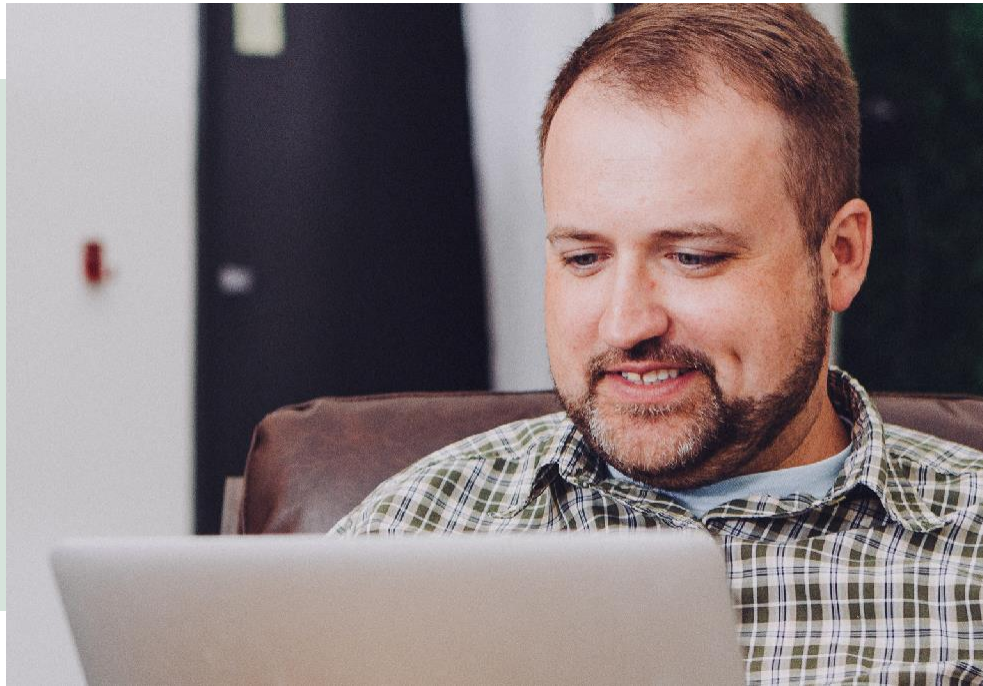
Calculate Premium Percentages		Monthly Amount
1	Use the Benefit Rates Chart and enter the premium amount for your Medical Plan. <i>Please keep in mind that if you select any of the Gold plans, you are responsible for the difference in cost between the Gold and Silver Plan (listed on the Benefit Rates Chart).</i>	
2	Use the Benefit Rates Chart and enter the premium amount for your Prescription Plan.	
3	Use the Benefit Rates Chart and enter the premium amount for your Dental Plan.	
TOTAL MONTHLY:		\$ -
TOTAL YEARLY COST:		\$ -
4	Use the Percentage of Premium Charts for your Level of Coverage to find your Salary Range and Percentage of Premium amount.	
5	Bi-Weekly Contribution Amount: CH 78% * Yearly Premium / 26 pays.	\$ -
Calculate Minimum Required Contribution		
<i>Employees must pay a minimum of 1.5% of Annual Salary</i>		
6	Enter your total Annual Salary.	
7	Multiply your Annual Salary by 1.5%.	1.5%
8	This is your 1.5% Minimum Annual Contribution as a Percentage of Salary.	\$ -
9	This is the minimum monthly amount you are required to contribute: Total Line 8 / 26 pays.	\$ -
Your Health Benefit Contribution		
10	Your Bi-Weekly Contribution is the larger amount of lines 5 and 9. This is Your Bi-weekly Required Contribution.	\$ -

Gold Plan Differential Monthly Contribution		Monthly Amount
1	Use the Benefit Rates Chart and enter the amount for your Gold Medical Plan Differential.	
2	Use the Benefit Rates Chart and enter the premium amount for your Dental Buy-up Plan Differential.	
ADDITIONAL BUY-UP MONTHLY COST:		\$ -

Flexible Spending Account

Contribution Limits & IRS Regulations

The IRS sets the maximum dollar amount you can elect and contribute to a medical FSA. The annual contribution limit for Cherry Hill Township is \$2,550. We recommend reviewing how much you spend on eligible healthcare expenses every year to determine how much to elect.



Funds on day 1

All of your FSA dollars are available on the very first day of the plan year. For example, if you choose to contribute \$1,200 to your FSA, your contributions will be deducted evenly across all of your paychecks for the year, but you have access to all \$1,200 on day 1! You can use your funds for expenses incurred by you, your spouse or eligible dependents.



Use-or-lose

Don't forget to spend your FSA dollars. You will forfeit any money left in your account at the end of the plan year. (Check with your employer to confirm how many days you have to submit claims for reimbursement after the plan year ends.)

Changing your FSA election

In order to make changes to your election after open enrollment, you need to experience a qualifying life event. These events include:

- Change in marital status
- Change in the number of dependents
- Increase due to birth, adoption or marriage
- Decrease due to death, divorce or loss of eligibility
- Gain or loss of eligibility due to a change in participant, spouse or dependent employment status

If you experience a qualifying life event, contact your employer to make changes to your election.



Dependent Care Flexible Spending Account

Why should I choose a dependent care FSA?

Dependent Care FSA is a benefit that allows you to choose how much of your paycheck you'd like to set aside, before taxes are taken out, for eligible dependent care expenses each year. The Dependent Care FSA lets you pay for eligible dependent care expenses while you reap the benefits of additional tax savings. You're spending the money either way. This way, eligible childcare and other dependent care costs are a little less.*

**Based on a 30% tax bracket.*

The IRS sets the maximum dollar amount you can elect and contribute to a Dependent Care FSA. The annual contribution limit is:

Per household - **\$7,500**, Per person (if married or filing separately) - **\$3,750**

Funds available as you contribute. Funds will be available to you as they're deducted from your paycheck and contributed to the plan. This means when payroll is processed and your paycheck is available to you, your Dependent Care FSA contributions will be applied to your account and available for reimbursement.

Use-or-lose. Don't forget to spend your FSA dollars. If you have not used all of your FSA dollars before the end of the plan year, you will forfeit any money left in your account. Check with your employer to confirm how many days you have to submit claims for reimbursement after the plan year ends.

Changing your Dependent Care FSA election. In order to make changes to your election after open enrollment, you need to experience a qualifying life event, such as:

- Change in marital status
- Change in the number of dependents
- Increase due to birth, adoption or marriage
- Decrease due to death, divorce or loss of eligibility
- Gain or loss of eligibility due to a change in participant, spouse or dependent employment status
- Change in daycare providers
- Child turning age 13
- Increase or decrease in the cost of qualifying daycare expenses
- Judgement, decree or order requiring a change in coverage

If you experience a qualifying life event, contact your employer to make changes to your election.

What does it cover?

The list includes, but is not limited to, eligible:

- Childcare center, babysitter, nanny (birth through age 12)
- Summer day camp
- Before or after-school care
- Disabled dependent and/or spouse care
- Elder care

Can I enroll?

You are eligible if you and/or your spouse (if applicable) are gainfully employed, looking for work, or are attending school on a full-time basis.

Flexible Spending Accounts Enrollment Form

Participant Information			
Employer Name: _____ Employee Name: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> (First Name) (Middle Initial) (Last Name) </div> SSN/EEID: _____ Current Address: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> (Street Address) </div> <div style="display: flex; justify-content: space-between; font-size: small;"> (Floor or Apt No.) </div> <div style="display: flex; justify-content: space-between; font-size: small;"> (City, State Zip) </div> Phone Number: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> (Cell Phone Number) (Home Phone Number) </div>	Employer/Location: _____ Date of Birth: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> <div> Gender: ☐ Male ☐ Female </div> <div> Marital Status: ☐ Single ☐ Married ☐ Married Filing Separately </div> </div>		
Health Care Spending Account: <p>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.</p> <div style="display: flex; align-items: center; justify-content: space-between;"> <div style="width: 30%;"> ☐ Yes, I want to participate ☐ No, I do not want to participate </div> <div style="width: 40%; text-align: center;"> <div style="display: flex; align-items: center; justify-content: center;"> \$ <div style="border-bottom: 1px solid black; width: 150px; margin: 0 auto;"></div> + <div style="text-align: center; margin: 0 10px;"> <div style="border-bottom: 1px solid black; width: 50px; margin: 0 auto;">26</div> <div style="font-size: small;"># Pay Periods in the Plan Year</div> </div> = \$ <div style="border-bottom: 1px solid black; width: 100px; margin: 0 auto;"></div> </div> <div style="display: flex; justify-content: space-around; font-size: small; margin-top: 5px;"> <div style="text-align: center;"> Plan Year Contribution Max of \$2,550 </div> <div style="text-align: center;"> Pay Period Pre-Tax Contribution </div> </div> </div> </div>			
Dependent Care Spending Account: <p>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.</p> <div style="display: flex; align-items: center; justify-content: space-between;"> <div style="width: 30%;"> ☐ Yes, I want to participate ☐ No, I do not want to participate </div> <div style="width: 40%; text-align: center;"> <div style="display: flex; align-items: center; justify-content: center;"> \$ <div style="border-bottom: 1px solid black; width: 150px; margin: 0 auto;"></div> + <div style="text-align: center; margin: 0 10px;"> <div style="border-bottom: 1px solid black; width: 50px; margin: 0 auto;">26</div> <div style="font-size: small;"># Pay Periods in the Plan Year</div> </div> = \$ <div style="border-bottom: 1px solid black; width: 100px; margin: 0 auto;"></div> </div> <div style="display: flex; justify-content: space-around; font-size: small; margin-top: 5px;"> <div style="text-align: center;"> Plan Year Contribution Max of \$7,500 (\$3,750 if filing taxes separate) </div> <div style="text-align: center;"> Pay Period Pre-Tax Contribution </div> </div> </div> </div>			
<p>I certify that I am not a sole proprietor, partner in a partnership or 2% or greater shareholder in an S-corporation.</p> <p>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.</p> <p>PLEASE SUBMIT THIS COMPLETED FORM TO BENEFITS COORDINATOR. LATE ENROLLMENTS WILL NOT BE ACCEPTED.</p> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div style="width: 60%;"> Participant Signature _____ </div> <div style="width: 35%;"> Date _____ </div> </div>			

