

TODAY'S DATE:

CLIENT INFORMATION

Riverside Board of Education

4233

028700, 0284000 - 0284099, 0285000 - 0285099, 028600 -

CLIENT NAME (PLAN SPONSOR / EMPLOYER)

0286099

CLIENT #

GROUP #

CARDMEMBER INFORMATION

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

PLEASE CHECK ONE:

<input type="checkbox"/> SINGLE	<input type="checkbox"/> CARDMEMBER/SPOUSE	<input type="checkbox"/> CARDMEMBER/CHILD	<input type="checkbox"/> CARDMEMBER/CHILDREN	<input type="checkbox"/> FAMILY	EFFECTIVE DATE: 7/1/2020
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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#
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EMPLOYER/PLAN SPONSOR	EFFECTIVE DATE
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SIGNATURES

MEMBER SIGNATURE	CLIENT SIGNATURE
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FOR INTERNAL USE ONLY:	DATE ENTERED: _____	ENTERED BY: _____	LOGGED BY: _____
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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

Riverside Township
Board of Education

Employees Hired
On/After 7/1/2020

Client ID # 4233 Group #: 0287000 (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

