THE EWING PUBLIC SCHOOLS

BUSINESS OFFICE
Payroll Department
Extensions 1501 & 1502
payroll@ewingboe.org

DISTRICT ADMINISTRATIVE OFFICES
2099 Pennington Road, Ewing NJ 08618
Phone 609-538-9800 Fax 609-538-0041
www.ewing.k12.nj.us

Employee Information

First Name	MI	Last Name	SSN#	Date of Birth	Gender

Address	City	State	Zip Code

Marital Status	Phone Number	Email Address	Date of Hire

Type of Activity

☐ New Enrollment ☐ Open enrollment

☐ Reinstate Member ☐ Terminate coverage

☐ Add dependent coverage (select one) ☐ Terminate dependent coverage (select one)

Date of event: Removing/adding: ☐ Medical ☐ Dental ☐ Prescription

Medical Coverage

I am: Level of coverage: Plan:

Medical plan selection:
*Medical plan must be selected regardless of enrolling/waiving
**Employees hired after 1/31/2017 are limited to identified medical plan selection
***Employees hired after 7/1/2020 are required to enroll into NJEHP or Garden State Health Plan for medical/prescription.
Please note: the Garden State Health Plan only includes providers in New Jersey.

Prescription Coverage

I am: Level of coverage:

Dental Coverage

I am: Level of coverage:

Spouse/Partner Information

First Name	MI	Last Name	SSN#	Date of Birth	Gender

Phone Number | Email address:

Dependent Information

First Name | MI | Last Name | SSN# | Date of Birth | Gender

Relationship to Employee: | Full-Time Student

First Name | MI | Last Name | SSN# | Date of Birth | Gender

Relationship to Employee: | Full-Time Student

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Relationship to Employee: | Full-Time Student

Employee Certification

☐ Supporting documentation is attached for adding/deleting dependent(s). Ex: Marriage certificate, birth certificates, legal documentation, etc.

☐ Student verification is attached for full-time students enrolled in dental coverage.

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. I also attest that the dependents listed here (if applicable) meet the dependent eligibility criteria of the plans. I understand that in the event I cover any dependent that does not meet the eligibility provisions of the plans that doing so shall invalidate their coverage and potentially my coverage and that I may be subject to penalties. I further agree that it may be requested at any time to supply evidence that substantiates the eligibility status of any person I cover as a dependent under the plans.

Employee Name | Employee Signature | Date