

EMPLOYEE DATA CHANGE REQUEST FORM



Monmouth County Human Resources Department
Hall of Records, 1 East Main Street, Freehold, New Jersey 07728
Email: MC.HumanResources@co.monmouth.nj.us

www.visitmonmouth.com
Phone 732-431-7300
Fax 732-431-7924

This form, and supporting documentation as noted, must be completed (printed or typed) and submitted to the Human Resources Department and a copy submitted to the employee's Department / Division. The Human Resources Department will forward a copy to the Finance Department and the Health Benefits Office. A change in your family status must be received for submittal to the Benefits Office within 30 days of the event. Please print the necessary forms attached to this package, complete and submit to the Human Resources Department or as otherwise noted.

Current Information:

Name: _____ Employee ID#: _____

Department: _____ Division: _____

Contact Telephone Number: _____ Effective Date: _____

New Information (check all changes that apply):

Name Change: _____

Mailing Address Change: _____

City / Zip Code Change: _____

Telephone Number Change: _____

Taxing Municipality Change: _____

(Please select one tax code for the physical location of your residence from the list on the next page)

For P.O. Box Number addresses the section below is required and must be completed:

Physical Residence Address: _____

City / Zip Code: _____

The following documents must be completed and / or attached to this form when submitted:

- Health Benefits Change form (used to change Health, Prescription, or Dental Benefits Plans)
- Marriage certificate, divorce papers, other legal reasons / documentation. Only legal name changes as shown on a Social Security card are acceptable. A copy of the Social Security card must be submitted with the other legal documents; otherwise, the change will not be processed.

The following documents only need to be submitted if you wish to make a change in your Federal or State tax deduction(s):

- Federal Form W-4
- New Jersey State Form W-4

The following forms are to be completed and mailed by the employee directly to the New Jersey State Division of Pensions and Benefits, P.O. Box 295, Trenton, NJ 08625. You may wish to make a copy for your file:

- Pension Affidavit – Change of Name Form
- Pension Designation of Beneficiary Form
- Pension Change of Address Form (if applicable)

For the following services, please contact the applicable Plan Administrator directly:

- Deferred Compensation: Nationwide Retirement Systems www.nrsservicecenter.com or 1-877-677-3678
- Voluntary Disability or Life Insurance: Colonial Life www.colonialnj.com or 1-856-983-9600
- Medical Flexible Spending Account: Insurance Administrators of America www.iaatpa.com or 1-888-599-1515

(Signature of Employee)

(Date)

TAXING MUNICIPALITY CODE LISTING

001 Aberdeen
017 Adelphia
002 Allenhurst
003 Allentown
052 Allenwood
004 Asbury Park
005 Atlantic Highlands
006 Avon
032 Belford
007 Belmar
008 Bradley Beach
009 Brielle
033 Clarksburg
001 Cliffwood/Beach
010 Colts Neck
051 Creamridge
011 Deal
012 Eatontown
027 Elberon
013 Englishtown
014 Fair Haven
015 Farmingdale
012 Fort Monmouth
016 Freehold Boro
017 Freehold Twp.
018 Hazlet
019 Highlands
020 Holmdel
021 Howell
051 Imbstown
022 Interlaken
023 Keansburg
024 Keyport
046 Lake Como
032 Leonardo
032 Lincroft
025 Little Silver
032 Locust
026 Loch Arbour
027 Long Branch
028 Manalapan
029 Manasquan
030 Marlboro
031 Matawan
032 Middletown
033 Millstone/Millstone Twp.
034 Morganville
030 Monmouth Beach
032 Navesink
036 Neptune City
035 Neptune Twp.
032 New Monmouth
049 New Shrewsbury

032 N. Middletown
037 Oakhurst
037 Ocean
035 Ocean Grove
038 Oceanport
033 Perrineville
032 Port Monmouth
039 Red Bank
040 Roosevelt
041 Rumson
042 Sea Bright
043 Sea Girt
044 Shrewsbury Boro
045 Shrewsbury
047 Spring Lake
048 Spring Lake Heights
028 Tennent
049 Tinton Falls
050 Union Beach
051 Upper Freehold
052 Wall
037 Wanamassa
037 Wayside
052 West Belmar
027 West End
018 West Keansburg
053 West Long Branch
030 Wicaktunk

Out of County

101 Atlantic County
102 Bergen County
103 Burlington County
104 Camden County
105 Cape May County
106 Cumberland County
107 Essex County
108 Gloucester County
109 Hudson County
110 Hunterdon County
111 Mercer County
112 Middlesex County
114 Morris County
115 Ocean County
116 Passaic County
117 Salem County
118 Somerset County
119 Sussex County
120 Union County
121 Warren County

Monmouth County Department of Human Resources

Hall of Records • One East Main Street • Freehold, NJ 07728
Phone: 732-866-3622 Fax: 732-780-3364

VisitMonmouth.com



Instructions For a Change of Name

If you change your name for any reason, please include with the Employee Data Change Request Form and email to MC.HumanResources@co.monmouth.nj.us

1. A copy of your Social Security card with your new name
2. A copy of your NJ driver's license or a NJ Identification card with your new name
3. If you are enrolled in a pension, please complete the "Affidavit - Change of Name" form. This form does not have to be notarized if you email it to MC.HumanResources@co.monmouth.nj.us

For a name change due to marriage, and you wish to enroll your new spouse in your existing medical, dental or vision insurance, please email the following to enrollments@co.monmouth.nj.us

1. Enrollment form(s)
2. A copy of your Marriage Certificate
3. A copy of your spouse's Social Security card
4. If you also wish to add any new stepchildren, please provide copies of their Social Security cards and Birth Certificates

For a name change due to divorce, and your ex-spouse was enrolled in your medical, dental or vision plans, then s(he) will need to be removed from these plans. Please email the following to enrollments@co.monmouth.nj.us

1. Enrollment form(s) with the proper notation removing your ex-spouse
2. A copy of your Divorce Decree

For any changes to your healthcare enrollments due to marriage or divorce, you must email the enrollment form(s) and the supporting documentation within thirty (30) days of the marriage or divorce to enrollments@co.monmouth.nj.us



County of Monmouth Medical Enrollment/Change Form

A. Employee Information Please read and complete the entire form. If you are making changes, please check box in part B. Even if you have no changes, read, complete and sign the form.

Last Name	First Name and Middle Initial	Social Security #	Date of Birth		Marital Status (select one)			
					<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Civil Union	<input type="checkbox"/> Divorced/Separated
Street Address		Apt #	City	State	ZIP Code	Email address (if available)		Union Name (if applicable)
Home Telephone ()	Work Telephone ()	Full-Time Hire Date	Hrs Worked Per Week	Effective Date	B. Coverage or Enrollment Change-Important! <input type="checkbox"/> Check this box if you are making any enrollment or plan changes since your last enrollment.			

C. Individuals Covered - List individuals for whom you are requesting coverage. Attach a sheet to list additional children.

Last Name, First Name, M.I.	Relationship to employee	(A)dd (C)hange (R)emove (K)eep	Date of Birth (MM/DD/YY)	Social Security Number	Gender M F	Other Health Coverage (✓ if Yes)
	Employee				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>
	Spouse/Civil Union Partner				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>
	Child				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>
	Child				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>
	Child				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>
	Child				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>

*For Horizon BCBS PCP information, visit www.Horizonblue.com, quick physician search; choose the Direct Access network for NJ Providers.

D. Plan Option & Coverage Level Selection

Carrier and Plan Selection	Check Box (select one)	Coverage Level Selection			
		From	To		
Horizon Direct Access PPO	<input type="checkbox"/>	Employee Only	<input type="checkbox"/>	Employee Only	<input type="checkbox"/>
Horizon Value Plan	<input type="checkbox"/>	Employee + 1 (Spouse or CU Partner)	<input type="checkbox"/>	Employee + 1 (spouse or CU Partner)	<input type="checkbox"/>
Horizon OMNIA	<input type="checkbox"/>	Employee and Child(ren)	<input type="checkbox"/>	Employee and Child(ren)	<input type="checkbox"/>
Waive Benefits	<input type="checkbox"/>	Family	<input type="checkbox"/>	Family	<input type="checkbox"/>

E. Other Insurance

F. Dependent Information

1. Is your Spouse/Civil Union Partner Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide name & address of his or her employer. 2. If "Yes" to Other Health Coverage (Section C), provide name & policy number of insurance carrier, HMO, or other source. Explain the circumstances. 3. If anyone listed on this enrollment form are enrolled in Medicare Parts A, B and/or D identify the coverage and provide the Medicare ID#.	1. Does any dependent listed in Section C live at a different address than the employee? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," who and what address? Explain the circumstances. 2. If any dependent's last name differs from yours, explain the circumstances.
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G. Employee Signature I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions on the reverse side/page 2 of this enrollment form.	Employee Signature – Required X _____ Date: / /	Employer Verification X _____ Date: / /	Horizon Enrollments Only Group Number-86260 Sub-Group number _____
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Employee – Complete Sections A – G

Section A – Employee Information:

Complete all information to order for your application to be processed.

Section B – Plan or Demographic Change Indicator:

Check this box if you are making any plan or enrollment changes since your last enrollment

Section C – Individuals Covered:

- x Print name(s) of your dependent(s), if applicable under the appropriate relationship. Circle whether spouse or civil union partner.
- x Add/Change/Remove/Keep – Use “A”, “C”, “R” or “K” to indicate whether you are adding, changing, removing, or keeping coverage for an individual.
- x Indicate Gender, Date of Birth, and Social Security Number for each individual listed.
- x Complete PCP information for all members including the employee.
- x If you or your dependent(s) have other Health or Rx drug coverage check off the “Yes” box(es) and complete Section E – Other Insurance at the bottom of the form

Note: If a dependent is disabled and being continued beyond the limiting age of 26, attach proof of disability.

- x From the appropriate provider directory or on-line, locate the PCP office ID number for the primary care physician. Indicate office ID selection(s) on the form and list PCP’s name and location.
- x If you are a current patient, please check “Current patient” box.

Section D – Plan Option and Coverage Level Selection:

- x Select Carrier and Plan Option
- x Indicate coverage level prior to 10/1/09 and after 10/1/09. This answer may or may not be the same depending upon if you have enrollment changes or not.

Section E – Other Insurance:

- x If you are including coverage for your spouse or civil union partner, answer question 1 regarding his or her employment status.
- x Answer questions 2 and/or 3 if you have indicated other health or rx coverage in section C.

Section F – Dependent Information:

- x Answer question 1 regarding dependents listed in Section C.
- x Answer question 2 if dependents have different last names than your own.

Section G – Employee Signature:

- x Read the acknowledgement and agreements section on the right side of this page
- x Employee must sign and date in order for the form to be processed.
- x Signature indicates agreement to terms and attests to complete, accurate, and true information.

Employee Acknowledgement and Agreements

On behalf of myself and the dependents listed on the reverse side/page1, I agree to or with the following:

1. a.) I authorize the sources stated below to give Horizon BCBSNJ or Horizon Healthcare of New Jersey, Inc., IAA or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage, and medical advice, treatment or supplies for any physical or mental condition. Authorized sources are: any physician or medical professional; any hospital clinic or other medical care institution; any carrier; any consumer reporting agency; any employer.
b.) I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which IAA, Horizon BCBSNJ or Horizon Healthcare of New Jersey, Inc. has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
c.) I know that I have a right to receive a copy of this authorization if I request one.
d.) I agree that a photocopy of this authorization is as valid as the original.
2. I acknowledge by enrolling in IAA, Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) or Horizon Healthcare of New Jersey, Inc. plan coverage is provided by in accordance with the contract.
3. Enrollment of myself and of the listed dependents into the plan is effective on acceptance by IAA, Horizon BCBSNJ or Horizon Healthcare of New Jersey, Inc.
4. I understand that my employer may request proof of dependent eligibility from time to time and I agree to provide appropriate documentation as requested.
5. I agree to inform my employer of any changes of dependent eligibility status within 30 days of a status change.

Misrepresentation

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

Employee healthcare deductions are automatically taken on a pretax, Section 125 plan basis to enable employees to take advantage of the obvious tax advantages. If for some reason, you would prefer not to have the deduction taken on a pretax basis, please call the Monmouth County Benefits Department at 732-866-3622 ext 7655, or 732-866-3622 ext 6671.

Waiver of Insurance Coverage

Notice of Special Enrollment Period

- x If you are declining enrollment for yourself and/or your eligible dependent(s) because of other health insurance coverage, or if you lose coverage, you may in the future be able to enroll yourself and/or your eligible dependent(s) in this plan, provided that you request enrollment within 30 days after your other coverage ends. If you are declining coverage for yourself and/or your eligible dependent(s) for any other reason, you cannot join the plan later unless you have a new dependent as a result of marriage, birth, adoption, placement for adoption, or during open enrollment period, if applicable. You may then be able to enroll yourself and your eligible dependent(s), provided that you request enrollment within 30 days after the marriage birth, adoption, or placement for adoption.
- x If you decline coverage for yourself and/or your eligible dependent(s) because of other health/dental coverage and you fail to fill out the front of this form concerning your (and/or your eligible dependent's) other coverage or if you fail to request plan enrollment within 30 days after your (and/or your eligible dependent's) other coverage ends, you will not be eligible to enroll yourself, or your eligible dependent(s) during the special enrollment period discussed above and you will need to wait until the next open enrollment period to enroll in the plan's health/dental coverage.

Instructions

Employer

- Complete the **Employer Group Information** in the upper right corner of the form.
- **Section A - Type of Activity:** Check box(es) indicating reason(s) for submitting The Enrollment Change Request Form.
If reason is other than indicated check **other** in box 2 and provide reason (i.e., rehire, open enrollment, newly eligible or previously refused/waived coverage).
- Complete **Section H - Employer Verification** in the lower right corner of the form.
 - Employer must complete this section for all new enrollments, coverage changes and terminations.
 - Employer must sign and date The Enrollment/Change Request Form in order for it to be processed.

Employee - Complete Sections B - G

Section B - Employee Information:

Complete **all** information in order for your application to be processed.

Section C - Plan Option:

- Check one Plan Option box, indicate Plan Option Name (where applicable).
- Select only an option offered by your employer.
- Select Contract Type: **S**-Single, **F**-Family, **2**-Adults (Husband/Wife, Domestic Partner or Civil Union Partner), **P/C**-Parent & Child

Section D - Individuals Covered:

- Add/Change/Remove - Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
- If a dependent is a full-time college student, you **must** attach a current course schedule or a letter from the school confirming full-time student status (12 or more credits). If dependent is disabled and being continued beyond the limiting age, attach proof of disability.
- If you or your dependent(s) have other dental coverage, check off the "Yes" box(es) and complete Section E - Other/Previous Insurance.
- If the Plan Option selected is Horizon Dental Choice or Horizon TotalCare Dental-from the appropriate Provider directory, locate the alphanumeric office ID code for the dentist. Indicate office ID number selection(s) and NPI Number on the form. Only one provider selection allowed under the Horizon TotalCare Dental Option per family
- If you are a current patient, please check the "Current Patient" box. (only applicable if the Plan Option selected is Horizon Dental Choice or Horizon TotalCare Dental).

Section E - Other/Previous Insurance:

Complete this section for all new enrollments or coverage changes. Coverage includes group, governmental and Medicare coverages and church plans.

Section F - Dependent Information:

Complete this section for all new enrollments or coverage changes. Coverage includes group, governmental and Medicare coverages and church plans.

Section G - Employee Signature:

- Complete this section for all new enrollments, coverage changes and terminations.
- Employee must sign and date the Enrollment/Change Request Form in order for it to be processed.

Section H - Employer Verification:

- Employer must complete this section for all new enrollments, coverage changes and terminations.
- Employer must sign and date the Enrollment/Change Request Form in order for it to be processed.

Conditions of Enrollment

Employee Acknowledgements and Agreements

On behalf of myself and the dependents listed on the reverse side, I agree to or with the following:

1. a) I authorize the sources stated below to give to Horizon BCBSNJ, or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition. Authorized sources are: any physician or medical professional; any hospital, clinic or other medical care institution; any carrier; any consumer reporting agency; any employer.
b) I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which Horizon BCBSNJ has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
c) I know that I have a right to receive a copy of this authorization if I request one.
d) I agree that a photocopy of this authorization is as valid as the original.
2. I acknowledge by enrolling in a Horizon BCBSNJ dental program, coverage is provided by Horizon BCBSNJ in accordance with the contract.
3. Enrollment of myself and of the listed dependents into the plan is effective on acceptance by Horizon BCBSNJ.
4. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. My employer is hereby authorized to withhold payments from my wages, as appropriate.

Misrepresentation

5. Any person who includes any false or misleading information on an application or enrollment form for a health benefits plan is subject to criminal and civil penalties.

ENROLLMENT/CHANGE REQUEST

Horizon BCBSNJ Vision Plan

www.horizonblue.com

www.davisvision.com

Group Information - To Be Completed by Employer

A. Type of Activity - To Be Completed by Employer Refer to instructions on back before completing this form. Print clearly.

Group Name	Group Number	Subgroup Number
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1. Enrollment <input type="radio"/> New Subscriber Effective Date ____/____/____ Date of Hire ____/____/____	2. Change - Check all that apply. Date of Event Reason <input type="radio"/> Add Spouse <input type="radio"/> Domestic Partner <input type="radio"/> Civil Union Partner ____/____/____ <input type="radio"/> Add Dependent Child ____/____/____ <input type="radio"/> Name Change ____/____/____ <input type="radio"/> Change Plan ____/____/____ <input type="radio"/> Other ____/____/____	3. Remove or Terminate - Check all that apply. Effective Date Reason <input type="radio"/> Remove Spouse/Domestic Partner/ Civil Union Partner* ____/____/____ <input type="radio"/> Remove Dependent Child* ____/____/____ <input type="radio"/> Employee Withdrawal/Termination ____/____/____ Note: Employee must be enrolled for spouse/domestic partner/civil union partner/ dependent(s) to have coverage. *Please complete Add/Change/Remove and Name columns in Section D.	4. Continuation of Coverage, i.e., COBRA, State, Total Disability Not all options are available. Contact Employer for available options. Coverage For: <input type="radio"/> Employee <input type="radio"/> Dependents Length of Continuation: <input type="radio"/> 18 mos <input type="radio"/> 29 mos* <input type="radio"/> 36 mos <input type="radio"/> Total Disability Date of Loss of Coverage: ____/____/____ Date of Qualifying Event: ____/____/____ *Attach proof of disability
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B. Employee Information - Complete Sections B – G

C. Plan Option - Your selection must be offered by your employer.

Social Security Number	Last Name, First Name, M.I.	Home Telephone () - - - -
Home Address		ZIP Code
Employer Name		Work Telephone () - - - -
Work Address		ZIP Code
Date of Employment	Hours Worked	

Horizon Panorama III III Alt B	Contract Type <input type="radio"/> S - Single <input type="radio"/> F - Family <input type="radio"/> 2 Adults <input type="radio"/> P/C - Parent & Child
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D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children.

	A)dd C)hange R)emove	Last Name, First Name, M.I.	Sex		Birthdate			Social Security Number					
			M	F	MM	DD	YYYY						
Employee			<input type="radio"/>	<input type="radio"/>	/	/							
Spouse			<input type="radio"/>	<input type="radio"/>	/	/							
Domestic Partner			<input type="radio"/>	<input type="radio"/>	/	/							
Civil Union Partner			<input type="radio"/>	<input type="radio"/>	/	/							
Child			<input type="radio"/>	<input type="radio"/>	/	/							
Child			<input type="radio"/>	<input type="radio"/>	/	/							
Child			<input type="radio"/>	<input type="radio"/>	/	/							

E. Dependent Information

Does any dependent listed in Section D live at a different address than the Employee? <input type="radio"/> Yes <input type="radio"/> No If "Yes," who and at what address? If any dependent's last name differs from yours, explain the circumstances.	Explain the circumstances.
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F. Employee Signature _____ **Date** _____

If you have any questions concerning the benefits and services provided by or excluded under this contract, contact a benefits representative at your company before signing this form.

G. Employer Verification - To Be Completed by Employer

I represent that all the information supplied in this enrollment/change request form is true and complete. I hereby agree to the conditions of enrollment on the reverse side of the employee copy of this enrollment/change request. I authorize deductions from my earnings for any required contribution.	Employee Signature - Required X Date ____/____/____	Employer Signature - Required X Title _____ Date ____/____/____
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Instructions

Employer

- Complete the **Employer Group Information** in the upper right corner of the form.
- **Section A - Type of Activity:** Check box(es) indicating reason(s) for submitting The Enrollment Change Request Form.
If reason is other than indicated check **other** in box 2 and provide reason (i.e., rehire, open enrollment, newly eligible or previously refused/waived coverage).
- Complete **Section G - Employer Verification** in the lower right corner of the form.
 - Employer must complete this section for all new enrollments, coverage changes and terminations.

Employee - Complete Sections B - F

Section B - Employee Information:

Complete **all** information in order for your application to be processed.

Section C - Plan Option:

- Check one Plan Option box, indicate Plan Option Name (where applicable).
- Select only an option offered by your employer.

Employee Acknowledgements and Agreements

On behalf of myself and the dependents listed on the reverse side, I agree to or with the following:

1. a) I authorize the sources stated below to give to Horizon BCBSNJ, or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition. Authorized sources are: any physician or medical professional; any hospital, clinic or other medical care institution; any carrier; any consumer reporting agency; any employer.
b) I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which Horizon BCBSNJ has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
c) I know that I have a right to receive a copy of this authorization if I request one. d) I agree that a photocopy of this authorization is as valid as the original.
2. I acknowledge by enrolling in a Horizon BCBSNJ vision program, coverage is provided by Horizon BCBSNJ in accordance with the contract.
3. Enrollment of myself and of the listed dependents into the plan is effective on acceptance by Horizon BCBSNJ.
4. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. My employer is hereby authorized to withhold payments from my wages, as appropriate.

Misrepresentation

5. Any person who includes any false or misleading information on an application or enrollment form for a health benefits plan is subject to criminal and civil penalties.

- Select Contract Type: **S**-Single, **F**-Family, **2**-Adults (Husband/Wife, Domestic Partner or Civil Union Partner), **P/C**-Parent & Child

Section D - Individuals Covered:

- Add/Change/Remove - Use “A”, “C”, or “R” to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.

Section E - Dependent Information:

Complete this section for all new enrollments or coverage changes.

Section F - Employee Signature:

- Employee must sign and date the Enrollment/Change Request Form in order for it to be processed.

Section G - Employer Verification:

- Employer must complete this section for all new enrollments, coverage changes and terminations.
- Employer must sign and date the Enrollment/Change Request Form in order for it to be processed.

DSO Dental Plan Enrollment/Change Form

Monmouth County

Employee Name: Last,		MI	Employee First Name:	
Birth Date:			Social Security Number	
Mailing Address:			City:	State: Zip:
Phone Number:	Sex:	Marital Status:		
	Female <input type="checkbox"/> Male <input type="checkbox"/>	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		

Complete the following information & sign form:
 Dependents children are covered to age 26.

DEPENDENTS:	Last Name, First	Date of Birth			
		Month	Day	Year	
<input type="checkbox"/> Husband					<input type="checkbox"/> Male
<input type="checkbox"/> Wife					<input type="checkbox"/> Female
<input type="checkbox"/> Child					<input type="checkbox"/> Male
<input type="checkbox"/> Stepchild					<input type="checkbox"/> Female
<input type="checkbox"/> Child					<input type="checkbox"/> Male
<input type="checkbox"/> Stepchild					<input type="checkbox"/> Female
<input type="checkbox"/> Child					<input type="checkbox"/> Male
<input type="checkbox"/> Stepchild					<input type="checkbox"/> Female
<input type="checkbox"/> Child					<input type="checkbox"/> Male
<input type="checkbox"/> Stepchild					<input type="checkbox"/> Female

I select Eastern Dental® of _____ as my primary care dentist.

Signature: _____ Date: _____