NJTRANSIT The Way To Go.

ACTIVE HEALTH CARE ENROLLMENT AND/OR CHANGE FORM

Employee Benefits Dept
180 Boyden Avenue
Maplewood, NJ 07040

Company Payroll: ☐ Bus ☐ HQ ☐ Rail ☐ Fop ☐ PBA ☐ Agreement ☐ Non- Agreement ☐ Morris	Emp #:	Employment Date:

Reason for Application: Check One

☐ New Enrollment ☐ Adding Dependents

☐ Open Enrollment ☐ Deleting Dependents

☐ Transfer ☐ Other:_____

☐ Cancellation _____

Coverage Requested:
Please check the appropriate box

Type of Contract:

	Single	Parent/ Child(ren)	Employee/ Spouse	Employee/ Domestic Partner	Employee/ Domestic Partner Family	Family	Effective Date
Traditional Medical:	☐	☐	☐	☐	☐	☐	_____
Horizon PPO:	☐	☐	☐	☐	☐	☐	_____
Horizon HMO:	☐	☐	☐	☐	☐	☐	_____
DA 10 (Rail Only):	☐	☐	☐	☐	☐	☐	_____
Dental:	☐	☐	☐	☐	☐	☐	_____
Vision:	☐	☐	☐	☐	☐	☐	_____

Employee Name (Last, First, M.I.)	Birthdate / /	Social Security No.	Gender ☐ M ☐ F
Address (No. Street, City, State and Zip Code)			
Home Telephone	Work Telephone		
Email Address			

Add	Delete	Full Name of List Eligible Dependents	Soc. Sec. No.	Circle Relationship	Date of Birth	Gender
☐	☐			Spouse/Domestic Partner/Child		☐ M ☐ F
☐	☐			Spouse/Domestic Partner/Child		☐ M ☐ F
☐	☐			Spouse/Domestic Partner/Child		☐ M ☐ F
☐	☐			Spouse/Domestic Partner/Child		☐ M ☐ F
☐	☐			Spouse/Domestic Partner/Child		☐ M ☐ F
☐	☐			Spouse/Domestic Partner/Child		☐ M ☐ F

☐ **Waive Coverage:** I have been offered the above coverage and I elect to waive participation for myself and my eligible dependents.

I hereby accept responsibility for payment of the appropriate portion of the premium, if applicable, based on my employment/retirement status and/or contractual agreement. I authorize Payroll or the appropriate pension administrator to commence deductions consistent with my elections.

I hereby certify that the foregoing information is true and correct to the best of my knowledge and accept the provisions of the plans outlined on this form.

Employee Signature: _____ Date: _____