



RAIL AGREEMENT ACTIVE HEALTH CARE ENROLLMENT AND/OR CHANGE FORM

Employee Benefits Dept
180 Boyden Avenue
Maplewood, NJ 07040
973-378-6142
Benefits@NJTRANSIT.com

Employee Name (Last, First, M.I.)	Employee ID #:	Employee Hire Date:
-----------------------------------	----------------	---------------------

Reason for Application: Check One <input type="checkbox"/> New Enrollment <input type="checkbox"/> Adding Dependents <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Deleting Dependents <input type="checkbox"/> Transfer <input type="checkbox"/> Other: _____ <input type="checkbox"/> Waive	Coverage Requested - Please check the appropriate box: <table style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width: 40%;"></th> <th style="width: 5%;">Single</th> <th style="width: 10%;">Parent/ Child(ren)</th> <th style="width: 10%;">Employee/ Spouse</th> <th style="width: 10%;">Employee/ Domestic Partner</th> <th style="width: 10%;">Employee/ Domestic Partner Family</th> <th style="width: 10%;">Family</th> <th style="width: 5%;">Effective Date</th> </tr> </thead> <tbody> <tr> <td>EPO</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td>PPO</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td>DA10 (Hired Pre-07.01.2016)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td>DA10 (Hired Post-06.30.2016)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="border-bottom: 1px solid black;"></td> </tr> </tbody> </table> <p style="margin-top: 10px;">NOTE: Prescription, Dental and Vision Benefits are Bundled with Medical Coverage</p>		Single	Parent/ Child(ren)	Employee/ Spouse	Employee/ Domestic Partner	Employee/ Domestic Partner Family	Family	Effective Date	EPO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		PPO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		DA10 (Hired Pre-07.01.2016)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		DA10 (Hired Post-06.30.2016)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Single	Parent/ Child(ren)	Employee/ Spouse	Employee/ Domestic Partner	Employee/ Domestic Partner Family	Family	Effective Date																																		
EPO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																			
PPO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																			
DA10 (Hired Pre-07.01.2016)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																			
DA10 (Hired Post-06.30.2016)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																			

Birthdate: _____ Social Security Number: _____ Gender: M F

Address (No. Street, City, State and Zip Code): _____

Home Telephone: _____ Work Telephone: _____

Email Address: _____



Add	Delete	Full Name of Eligible Dependents	Soc. Sec. No.	Circle Relationship	Date of Birth	Gender
<input type="checkbox"/>	<input type="checkbox"/>			Spouse/Domestic Partner/Child		<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/>	<input type="checkbox"/>			Spouse/Domestic Partner/Child		<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/>	<input type="checkbox"/>			Spouse/Domestic Partner/Child		<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/>	<input type="checkbox"/>			Spouse/Domestic Partner/Child		<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/>	<input type="checkbox"/>			Spouse/Domestic Partner/Child		<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/>	<input type="checkbox"/>			Spouse/Domestic Partner/Child		<input type="checkbox"/> M <input type="checkbox"/> 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: _____