Gateway BMED Fund

c/o PERMA, 401 Route 73 North, Suite 300, Marlton, NJ 08053

Employee/Participant Information (Employee, Surviving Spouse, Dep. 31, Retiree)

Please **PRINT** and fill this section out **COMPLETELY**

Social Security #:	Last Name:		First Name:	M.I.:
Gender: ☐ Male ☐ Female	Date of Birth:		Address:	
City:	State:	Zip:	Home Phone #:	Work Phone #:
E-mail:		PCP code (if required):	Division (if any):	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed		Are you Medicare eligible? ☐ No ☐ Yes because of age ☐ Yes because of disability		
Change Due to Medicare Status? ☐ Yes ☐ No *Attach copy of Medicare Card		Is your spouse Medicare eligible? ☐ No ☐ Yes because of age ☐ Yes because of disability		

Dependent Information (Spouse, Child or Children)

Please **PRINT** and fill this section out **COMPLETELY**

Please list all eligible dependents only. If dependent is a full-time student under the terms of the Plan, or is disabled, please attach documentation of student status or disability to determine coverage beyond the Plan's maximum dependent age. Provide copy of court order or proof of residency for stepchildren or foster children.

Spouse

Social Security #:	First Name:	Last Name:	M.I.:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP code (if required):	

Child(ren)

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP code (if required):	
Full-Time Student? ☐ Yes ☐ No			
Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP code (if required):	
Full-Time Student? ☐ Yes ☐ No			
Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP code (if required):	
Full-Time Student? ☐ Yes ☐ No			

Completed by Employer

Employer Name:	
Action to be Taken: ☐ New Enrollment – Effective Date: _____	Signature of Certifying Officer:
☐ Return from Leave of Absence – Effective Date: _____	Phone #:
☐ Enrollment Change – Effective Date: _____	Date Mailed:

Benefit Elections

Medical Coverage

☐ I wish to enroll

First Carrier Name: _____ Plan Name/Copay: _____

Type of Coverage: ☐ Single ☐ Family ☐ Husband/Wife ☐ Parent/Child(ren)

☐ I wish to change plans coverage ☐ I elect not to enroll in any medical plan ☐ I wish to cancel my medical

Other Group Health (If yes, please attach a copy of the front & back of the ID card for that coverage. Please indicate the name & address of the other carrier.)

☐ No ☐ Yes _____

Prescription Drug Coverage

☐ I wish to enroll

Carrier Name: **Express Scripts** Plan Name/Copay: _____

Type of Coverage: ☐ Single ☐ Family ☐ Husband/Wife ☐ Parent/Child(ren)

☐ I wish to change plans coverage ☐ I elect not to enroll in any medical plan ☐ I wish to cancel my medical

Dental Coverage

☐ I wish to enroll

Carrier Name: **Delta Dental of New Jersey** Plan Name: _____

Type of Coverage: ☐ Single ☐ Family ☐ Husband/Wife ☐ Parent/Child(ren)

☐ I wish to change plans ☐ I elect not to enroll in any medical plan ☐ I wish to cancel my medical coverage

Type of Activity

☐ New Hire Date: _____ ☐ Open Enrollment Date: _____ ☐ Rehire Date: _____

☐ Termination of Employment

Date: _____

☐ COBRA (please check box indicating reason for COBRA eligibility):

- ☐ Employment Terminated ☐ Reduction in hours ☐ Divorce
- ☐ Spouse/dependent child of deceased employee ☐ Loss of dependent child status under plan rules
- ☐ Spouse/dependent's loss of coverage due to employee's Medicare entitlement

Retirement

Date of Retirement: _____ ☐ Retaining coverage with the Fund

☐ Town Paid Benefits: ☐ Medical ☐ Dental ☐ Rx ☐ Vision ☐ Direct Bill Retiree: ☐ Medical ☐ Dental ☐ Rx ☐ Vision

Addition of Dependent (legal documentation required)

☐ Marriage ☐ Civil Union ☐ Birth ☐ Adoption/Guardianship/Foster Care **Date of Event:** _____

Add Coverage: ☐ Medical ☐ Dental ☐ Rx ☐ Vision

Deletion of Dependent **Date of Event:** _____ **Dependent Name:** _____

☐ Divorce (legal documentation required) ☐ Death of spouse or child ☐ Child over age limit/ineligible

Remove Coverage: ☐ Medical ☐ Dental ☐ Rx ☐ Vision

Other

☐ Dependent Age 31 ☐ Newly Eligible (PT or FT) ☐ Death (Name of Deceased: _____ Date of Death: _____

☐ Other (Give Reason): _____

Other Group Health (If yes, please attach a copy of the front & back of the ID card for that coverage. Please indicate the name & address of the other carrier.)

☐ No ☐ Yes _____

Employee Certification

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. If either my physician or medical center terminates participation in the Plan, I must select another doctor or medical center participating in the same plan. I authorize any hospital, physician or health care provider to furnish my medical plan or its assignee with such medical information about myself or my covered dependents as the medical plans or assignee may require.

Print Name: _____ Employee Signature: _____ Date: _____