Newark
Board of Education
Roger León, Superintendent

Enrollment Form / Payroll Authorization

Employee Information

Please provide all requested information

Last Name:	First Name:	M.I.	Social Security Number:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow
Address:			Date of Birth:	Gender ☐ M ☐ F / Date of Hire:
City:	State:	Zip:		Home Phone Number:
Employee ID:			Please Enter Your Title:	

Please check the box for your current Union:

☐ NTU ☐ Local 3 ☐ Local 617 ☐ Local 32 ☐ Local 68 ☐ NTA ☐ CASA ☐ Unaffiliated/Non-Union ☐ BTC

Type of Enrollment

☐ New Hire	☐ Open Enrollment	☐ Life Event Please specify (i.e. Marriage, birth, divorce, etc.)	☐ Address Change
Effective Date: _______________	Effective Date: _______________	_______________________________	Effective Date: __________
	☐ **FSA/DCA** Effective Date: ______________	Effective Date: _________________	

IMPORTANT: Proof of a life event is required! Please provide documentation (Required Social Security Card, W2, or Joint Debt, divorce decree, birth certificate, adoption paperwork, etc.) to Human Resource Services-Benefit Services within 60 days of your life event or coverage will be affected.

Medical Coverage Options

Please Check (☑) one box

Control Number: 285515		Single	Parent + Child(ren)	EE + Spouse / Civil Union Partner	Family	PCP Office ID Number Required (if selecting any of the HMO Plans)
Aetna PPO 10 Plan (Local 68 Only)	11 001	☐	☐	☐	☐	N/A
Aetna PPO 15 Plan (Local 68 Only)	11 002	☐	☐	☐	☐	N/A
Aetna PPO 1525 Plan (Local 68 Only)	11 003	☐	☐	☐	☐	N/A
Aetna PPO 1015 Plan	11 004	☐	☐	☐	☐	N/A
Aetna PPO 2035 Plan	11 005	☐	☐	☐	☐	N/A
Aetna HMO 10 Plan	10 001	☐	☐	☐	☐	
Aetna HMO 1525 Plan	10 002	☐	☐	☐	☐	
Aetna HMO 2020 Plan	10 003	☐	☐	☐	☐	
Aetna HMO 2035 Plan	10 004	☐	☐	☐	☐	
Aetna HDHP 1500 Plan	13 001	☐	☐	☐	☐	N/A
I elect to waive medical coverage in any medical plan.						☐

Health Savings Account (HSA) – only for those in HDHP 1500 Plan

Please check (☑) all boxes that apply

PayFlex Health Savings Account (HSA)	☐ Yes, I want to enroll in the Health Savings Account (HSA) Annual Election Amount $_______________ Check One: ☐ 10-month employee (maximum Individual $3,500; Family $7,000) Additional $1,000 as “Catch Up” if over age 55 ☐ 12-month employee Per Pay Deduction Amount $_______________ *** If enrolling in the Health Savings Account HSA please see back page of this enrollment form for more information.**	Waive ☐

Name | Employee ID Number

Prescription Coverage Option					Please check (☑ one box
	Single	Parent + Child(ren)	EE + Spouse / Civil Union Partner	Family	Waive
Aetna	☐	☐	☐	☐	☐

Vision Coverage Option					Please check (☑) one box
	Single	Parent + Child(ren)	EE + Spouse / Civil Union Partner	Family	Waive
Aetna	☐	☐	☐	☐	☐

Dental Coverage Options						Please check (☑) one box
	Single	Parent + Child(ren)	EE + Spouse / Civil Union Partner	Family	Dentist Office ID Number Required (if selecting the Dental Choice Plan)	Waive
Aetna PPO	☐	☐	☐	☐	N/A	☐
Aetna DMO	☐	☐	☐	☐		☐

Health Care Flexible Spending Account (FSA)	Please check (☑) all boxes that apply	
Benefit Express Health Care FSA	☐ Yes, I want to enroll in the Health Care FSA Annual Election Amount $__________ Check One: ☐ 10-month employee (minimum $100; maximum $2,700) ☐ 12-month employee Per Pay Deduction Amount $__________	Waive ☐

Dependent Care Flexible Spending Account (DCA)	Please check (☑) all boxes that apply	
Benefit Express Dependent Care FSA	☐ Yes, I want to enroll in the Dependent Care FSA Annual Election Amount $__________ Check One: ☐ 10-month employee (minimum $100; maximum $5,000 Joint, $2,700 Separate) ☐ 12-month employee Per Pay Deduction Amount $__________	Waive ☐

Name Employee ID Number

Dependent's Information				Please provide all requested information and check (☑) all boxes that apply					
Dependent's First Name, Middle Initial & Last Name	Relationship SP = Spouse CU = Civil Union C = Child	Date of Birth (MM/DD/ YY)	Social Security Number	Gender	Medical	Rx	Vision	Dental	PCP and/or Dentist Designation
				☐ M ☐ F	☐	☐	☐	☐	
				☐ M ☐ F	☐	☐	☐	☐	
				☐ M ☐ F	☐	☐	☐	☐	
				☐ M ☐ F	☐	☐	☐	☐	
				☐ M ☐ F	☐	☐	☐	☐	
				☐ M ☐ F	☐	☐	☐	☐	
				☐ M ☐ F	☐	☐	☐	☐	

Applicant Statement of Understanding

I hereby declare, under penalty of perjury, that the information that I provided on this form is accurate and complete, and if applicable, that the dependents that I am enrolling in coverage or opting out of coverage are my legal dependents and meet the definitions outlined in the plan documents.

If I am opting out myself or any of my dependents, I attest and have provided the required documentation, that I/we have alternative and comparable coverage from an alternative source for the upcoming plan year. If I fail to provide proof of other coverage within 60-days from the date of hire, I will be enrolled into the District's health coverage under the single tier coverage for Preferred Provider Organization (PPO) 2035 medical plan and the Prescription plan. To remove myself from this coverage, I will be required to wait for Open Enrollment on October 1st – 31st, and coverage will end effective January 1st of the following year. I understand that if I lose this coverage during the upcoming plan year, that it is my responsibility to inform Newark BOE within 60 days, so that I, or any of my eligible family members, may become covered under the Newark BOE Pl an. I understand that the Newark BOE reserves the right to require proof of valid dependent eligibility status in conjunction with the operation of both its benefit and opt out programs and if I fail to provide the necessary required documentation, then the Newark BOE will terminate coverage for these dependents. Further, I understand that I will be required to reimburse the Newark BOE for all insurance premiums or opt out dollars paid if the Newark BOE determines that my dependents were not eligible for coverage or if we did not have alternative and comparable coverage.

I understand that IRS §125 prohibits me from changing my enrollment during the Plan Year, unless I experience a qualifying life event. A qualifying event includes a marriage, divorce, death of a spouse/civil union partner or a dependent, birth or adoption of a child, termination, or commencement of employment for my spouse/civil union partner, a change in employment status (full-time to part-time or part-time to full-time) for me or my spouse/ civil union partner that affects benefits eligibility, or taking an unpaid, medical leave of absence by either me or my spouse/civil union partner. If I experience one of these qualifying events, I understand that I am obligated to notify Human Resource Services – Office of Benefit Services within 60 days and that failure to do so may affect benefits coverage.

I, as a new employee, or per diem to permanent employee, have a 60-day grace period for medical, vision, dental, and prescription coverage to begin. With the exception of 10-month employees, who are hired effective the first day of the school year up to September 15th, then my benefits coverage becomes effective the date of hire. If applicable, NTU members hired after September 15th will have dental, vision, and prescription coverage becomes effective on the date of hire, while medical coverage commences 60-days from date of hire.

I understand that if I elect medical and/or prescription drug benefits that require employee contributions, my employer will deduct this amount from my before-tax income. I understand that if I elect dental and/or vision coverage, there will be no employee contributions. I also understand that this salary reduction authorization can only be changed during open enrollment periods, unless I experience a qualifying event defined by law. I understand as a new employee, or per diem to permanent employee, I have a 60-day grace period, but should expect payroll deductions to commence two pay cycles, or one month, prior to date of active benefits coverage. If applicable, 10-month employees who are hired effective the first day of school year to September 15th will have payroll deductions taken effective the date of hire.

My signature below indicates that I have read and understood this Enrollment & Authorization Form and the descriptive materials made available to me under the Newark BOE Employee Benefits Program. I certify that the information that I have provided on this form is complete and accurate to the best of my knowledge.

Employee Signature ____________________ Date ________

For those enrolling in the HDHP 1500 Plan: Qualifying for an HSA

To be an eligible individual and qualify for an HSA, you must meet the following requirements:

- ☐ You must be covered under an HDHP, on the first day of the month
- ☐ You have no other health coverage
- ☐ You are not enrolled in Medicare
- ☐ You cannot be claimed as a dependent on someone else's tax return
- ☐ You cannot have a full scope FSA or HRA
- ☐ Your spouse can not have a full scope FSA

For Human Resource Services – Office of Benefit Services Use Only:

Date Received: ______________ Received by: ______________ Benefits Effective Date: ______________

Employee Type: ☐ 10-month employee

☐ 12-month employee