PATERSON PUBLIC SCHOOLS

Department of Human Resources
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Lynette Gonzalez
Director of Employee Services
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Laurie W. Newell PhD
Superintendant of Schools

To: All District Employees

From: Lynette Gonzalez

Re: Health Benefits: Enrolling/Deleting of Dependents

Date: November 17, 2023

Please contact the Health Benefits Department within 30 days of your life event to get the proper forms to add your dependent(s) to health benefits. Eligible dependents include a spouse, civil union partner, or same-sex domestic partner and/or your eligible children. Documentation such as copies of birth certificates, marriage certificates, divorce decrees, social security cards, etc, will be requested once the enrollment form is submitted. You can reach the Employee Benefits Office at 973-321-0745.

The age limit for dependent coverage is listed below:

- Medical: Coverage expires at the end of the year when the dependent turns 26
- Prescription: Coverage expires at the end of the year when the dependent turns 26
- Dental: Coverage for all dependents begins at age 2 and expires the day before the dependent turns 24
- Vision: Coverage expires at the end of the year when the dependent turns 23

Once your dependent(s) reach the age limit, the District offers Cobra (18 months) or they may be eligible for Chapter 375 (until age 31) if they wish to continue coverage.

Thank you for your consideration in this matter.

PATERSON PUBLIC SCHOOLS

Life Event Enrollment Form

Dependents Form

EMPLOYEE CERTIFICATION: I certify that all the information supplied on this form is true to the best of my knowledge and that it is verifiable. I understand that if I waive right to coverage at this time, enrollment is not permissible until the next scheduled open enrollment I also understand this form is solely for the purpose of adding or deleting dependents.

Employee Signature: _____	Date: ____/____/____

Today's Date:	Date of Hire:			
Reason for Open Enrollment change is due to:				
☐ Adding Dependents ☐ Deleting Dependents				
Employee Name (Last, First)	**Date of Birth**	**Social Security #**		**Gender**
				M( ) F( )
Street Address	**City**	**State**	**Zip Code**	**Home Phone**
				( )

MEDICAL	☐ Employee only	☐ Employee plus spouse	☐ Employee plus children	☐ Employee plus family	☐ **I am WAIVING MEDICAL coverage.**
PRESCRIPTION	☐ Employee only	☐ Employee plus spouse	☐ Employee plus children	☐ Employee plus family	☐ **I am WAIVING PRESCRIPTION coverage.**
DELTA DENTAL OF NJ	☐ Employee only	☐ Employee plus spouse	☐ Employee plus children	☐ Employee plus family	☐ **I am WAIVING DENTAL coverage.**
VISION SERVICES PLAN	☐ Employee only	☐ Employee plus spouse	☐ Employee plus children	☐ Employee plus family	☐ **I am WAIVING VISION coverage.**

Dependent Information: List all eligible dependents and attach required proof of dependency documents. **Any dependents not added will be removed.**

Eligible Dependents Last Name, First Name	Social Security No.	Relationship	Birth Date	Gender

EMPLOYEE CERTIFICATION---I certify that all the information supplied on this form is true to the best of my knowledge and that it is verifiable. I understand that if I waive my right to coverage at this time, enrollment is not permissible until the next scheduled open enrollment or if other coverage is lost and proof of loss is provided (HIPAA). I also understand that there is no guarantee of continuous participation by medical providers, either doctors or facilities, in the plans. If either my physician or medical center terminates participation in my selected plan, I must select another doctor or medical center participating in that plan to receive the "in-network" benefit. 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 assignee may require. **Misrepresentation:** Any person that knowingly provides false or misleading information is subject to criminal and civil penalties pursuant to N.J.S.A. 17:33A-6c.

Employee Signature:	**Date:** ____/____/____