Enrollment Form
For the 2025 Plan Year

PLEASE READ THESE INSTRUCTIONS BEFORE YOU BEGIN:

- **This is an ACTIVE open enrollment which means you MUST complete this enrollment form. If you are currently enrolled in a Medical, Prescription, Dental or Vision your elections WILL NOT carry over for the 2025 plan year. You MUST complete an enrollment form prior to November 27, 2024.**
- **If you are enrolling or making plan election changes to Medical, Prescription Drug, Dental and/or Vision benefits for you or your covered dependents, you MUST complete this enrollment form. Note: section 7 dependent information must be provided.**
- **If you would like to participate in the Flexible Spending Account (FSA) for 2025, you must enroll each year. Please complete Section 1 and Section 6 of this form if you would like to be enrolled in the Health Care and/or Dependent Care FSA and proceed to page 3 to sign and date your enrollment form.**
- **If you would like your payroll contributions taken out Post Tax, you must complete Section 1 then proceed to page 3 and check the box for *Waiver of Pre-tax Benefits Under the Salary Reduction Plan*, and sign and date your enrollment form.**
- **Employees MUST return to Human Resources on or before November 27, 2024.**

SECTION 1: EMPLOYEE INFORMATION			Please provide all requested information.		
Last Name:	First Name:	M.I.:	Social Security Number:	Marital Status: ☐ Single ☐ Married ☐ Civil Union ☐ Divorced	
Address:			Date of Birth:	Gender:	Email:
City:	State:	Zip:		Home Phone Number:	

SECTION 2: 2025 MEDICAL COVERAGE OPTIONS

Please check (✓) only one box to indicate your Horizon medical plan. If you are waiving medical coverage please check (✓) waive.

	Waive – check ONLY if you are waving medical	Horizon Direct Access 10 Plan	Direct Access $25/$50 Plan with HRA Difference Card	Horizon OMNIA Plan
Employee	☐	☐	☐	☐
Employee + Spouse / Civil Union Partner	☐	☐	☐	☐
Employee + Child(ren)	☐	☐	☐	☐
Employee, Spouse and Child(ren)	☐	☐	☐	☐

SECTION 3: 2025 PRESCRIPTION DRUG COVERAGE OPTION

Please check (✓) only one box to indicate your Horizon prescription plan. If you are waiving prescription coverage please check (✓) waive.

Carrier	Waive – check ONLY if you are waiving prescription drug coverage	Horizon BCBS of NJ
Employee	☐	☐
Employee + Spouse / Civil Union Partner	☐	☐
Employee + Child(ren)	☐	☐
Employee, Spouse and Child(ren)	☐	☐

YOU MUST SIGN AND RETURN THE LAST PAGE.

SECTION 4: 2025 DENTAL COVERAGE OPTION

Please check (✓) only one box to indicate your Horizon dental plan. If you are waiving dental coverage please check (✓) waive.

Carrier	Waive – check ONLY if you are waiving dental coverage	Horizon BCBS of NJ
Employee	☐	☐
Employee + Spouse / Civil Union Partner	☐	☐
Employee + Child(ren)	☐	☐
Employee, Spouse and Child(ren)	☐	☐

SECTION 5: 2025 VISION COVERAGE OPTION

Please check (✓) only one box to indicate your UniteHealthcare vision plan. If you are waiving vision coverage please check (✓) waive.

Carrier	Waive – check ONLY if you are waiving vision coverage	United Healthcare
Employee	☐	☐
Employee + Spouse / Civil Union Partner	☐	☐
Employee + Child(ren)	☐	☐
Employee, Spouse and Child(ren)	☐	☐

SECTIONS 6: 2025 FLEXIBLE SPENDING ACCOUNT OPTION

*There are 24 pay periods in a year. Please indicate how much you would like to contribute to each (or both) FSAs for the entire year.

Healthcare FSA minimum amount you can elect is $100; maximum amount you can elect is $3,300	**I wish to contribute $_____ to my Healthcare FSA for the 2025 Plan Year.**
Dependent Care FSA minimum amount you can elect is $100; maximum amount you can elect is $5,000 if filing single or married filing jointly ; or $2,500 if you are married filing separately	**I wish to contribute $_____ to my Dependent Care FSA for the 2025 Plan Year.**

SECTION 7: DEPENDENT 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 or C=Child	Date of Birth (MM/DD/YY)	Social Security Number	Gender (M/F)	Medical	Rx	Dental	Vision
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐

***If enrolling more than six dependents for coverage, please write all information on additional sheet of paper.**

I understand that under the ("the Plan"), I can pay for my share of employer-sponsored insurance premiums with pre-tax dollars. Alternatively, I can decline pre-tax salary reduction (in favor of an after-tax payment), or I can waive coverage if I have other insurance coverage.

WAIVER OF PRE-TAX BENEFITS UNDER THE SALARY REDUCTION PLAN; ELECTION OF AFTER-TAX BENEFITS *(Check box if applicable; do not check this box if you want to pay your contribution with pre-tax dollars)*

☐ I elect to waive the pre-tax premium benefits under the Plan. I understand that I have enrolled for insurance coverage and I will pay my share of the contribution after-tax payroll deductions. Except for a change in election event for insurance coverage, I understand that I cannot elect pre-tax benefits until the next Open Enrollment Period, and any after-tax coverage's shall be outside the Plan. I understand my contributions will be paid on an after-tax basis and that I will be required to check off the box for the Waiver of Pre-Tax Benefits Under the Salary Reduction Plan election each year in order to continue my after-tax election.

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 that I/we have alternative and comparable coverage from an alternative source for the upcoming Plan Year. I understand that if I lose this coverage during the upcoming Plan Year, that it is my responsibility to inform the Township within 30 days, so that I, or any of my eligible family members, may become covered under the Township Plan. I understand that the Township 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 Township will terminate coverage for these dependents. Further, I understand that I will be required to reimburse the Township for all insurance premiums or opt out dollars paid if the Township 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 the Human Resources Department and submit a new enrollment form within 30 days of the life event. Failure to do so may affect benefits coverage.

My signature below indicates that I have read and understood this Enrollment & Authorization Form and the descriptive materials made available to me under the Little Egg Harbor Township Employee Benefits Program. I understand that if I elect medical, prescription drug, dental and/or vision benefits that require employee contributions, my employer will deduct this amount from my before-tax income. I also understand that this salary reduction authorization can only be changed during initial enrollment periods, unless I have a change in family status as defined by law. I certify that the information that I have provided on this form is complete and accurate to the best of my knowledge.

THE TOWNSHIP DISCLAIMS ALL LIABILITY FOR THE LOSS OF HEALTH BENEFITS TO ANY EMPLOYEE, RETIREE OR DEPENDENT(S) THAT RESULTS FROM THE FAILURE TO COMPLETE, SIGN AND SUBMIT THE ENROLLMENT APPLICATION.

Employee Signature **Date**

YOU MUST SIGN AND RETURN THIS FORM ON OR BEFORE NOVEMBER 27, 2024 IN ORDER TO CHANGE OR WAIVE COVERAGE FOR THE 2025 PLAN YEAR.

For Human Resources Use Only:

Date Received: _____ Received by: _____ Benefits Effective Date: _____