GROUP ENROLLMENT/CHANGE REQUEST

Carrier Name: **MaxorPlus Ltd.**

MAXOR PLUS®
Pharmacy Benefit Management Services

Group Information – to be completed by [Employer]:

Group Name: **Essex County Vocational-Technical Schools**

Group Number: (Check One)

- ☐ ECV01 – Technical Career Ctr
- ☐ ECV02 – Bloomfield Tech
- ☐ ECV04 – N. 13th Street
- ☐ ECV05 – S. Clinton Street
- ☐ ECV07 – W. Caldwell
- ☐ ECV08 – Central Office

A. Type of Activity – to be completed by [Employer]. *Refer to instructions /before completing this form. Print clearly.*

	Activity – Check all that apply	Effective Date/ Date of Event	Date of Hire/Reason for Change
1. ADD	☐ Enrollment of a new [Employee/Subscriber] ☐ Add Spouse/Civil Union Partner ☐ Add Domestic Partner ☐ Add Dependent Child ☐ Add Over-Age Child as a Dependent Under 31 *(and complete section A 4)*	___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___	Date of Hire: ___/___/___
2. REMOVE	☐ [Employee] Withdrawal/Termination ☐ Remove Spouse/Civil Union Partner ☐ Remove Domestic Partner ☐ Remove Dependent Child ☐ Remove Over-Age Child as a Dependent Under 31	___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___	
3. OTHER	☐ Name Change ☐ Change Plan ☐ Other _____	___/___/___ ___/___/___ ___/___/___	

4. COVERAGE CONTINUATION

☐ For Employee
- ☐ Total Disability*
- ☐ COBRA/NJSGC **(MP Region Code = C)**
  - Length of Continuation (in months): ☐ 18 ☐ 29
  - Date of Loss of Coverage: ___/___/___
  - Qualifying Event #:_____**
  - Date of Qualifying Event: ___/___/___

[Billing: ☐ Group ☐ Home (Section B)]

**Attach proof of disability*

☐ For Spouse/Civil Union Partner*
- Length of Continuation (in months): ☐ 18 ☐ 36
- Date of Loss of Coverage: ___/___/___
- Qualifying Event #:_____**
- Date of Qualifying Event: ___/___/___

[Billing: ☐ Group ☐ Home (what address?) ☐ Section B *OR* ☐ Section [F]]

**Civil union partners are eligible to make an election pursuant to NJSGC, if applicable..*

☐ For Dependent or Over-age Child
- ☐ COBRA/NJSGC **(MP Region Code = C)**
  - Length of Continuation (in months): ☐ 18 ☐ 36
  - Loss of Coverage: ___/___/___
  - Qualifying Event #:_____**
  - Date: ___/___/___
- ☐ Dependent Under 31 **(MP Region Code = DU31)**
  - Qualifying Event #:_____**

[Billing: ☐ Group*** ☐ Home (what address?) ☐ Section B *OR* ☐ Section [G]]

***Qualifying event #s: see list in Instructions. [***Billing through the group for a Dependent Under 31 Continuation Election requires agreement by the employer at Section [L] .]*

B. [Employee] Information – to be completed by the [Employee]	Name (Last, First, MI):	SSN:
Home	Street/Apt: Street/Apt: City: State: Zip Code:	Birthdate (mm/dd/yyyy): ☐ Male ☐ Female Phone: ( ) Email:
Work	[Employer] Name: Address: City: State: Zip Code:	Phone: ( ) Employment Date: / /
Other Health Coverage? ☐ Yes ☐ No *If yes:* Payer Name: Policy #: Medicare ID#, if any:		Other Rx Coverage? ☐ Yes ☐ No *If yes:* Payer Name: Policy #: Medicare ID#, if any:
Previous Coverage? ☐ Yes ☐ No *If Yes:* Effective date: / / Termination date: / /		Payer Name: Policy #: [*Submit a Certificate of Creditable Coverage*]

C. Plan Option – to be completed by the [Employee] **MaxorPlus Prescription Drug Coverage**

D. Other Individuals Covered – to be completed by the [Employee] *Identify individuals other than yourself for whom you are adding/changing/removing/continuing coverage. Attach additional pages if necessary, with your signature and dated.*

1. Spouse; Domestic or Civil Union Partner (MP Person Code=02)	2.Child (MP Person Code=03)	3. Child (MP Person Code=04)	4. Child (MP Person Code=05)
☐ Add ☐ Remove ☐ Other ☐ Continue Spouse ☐ Continue CU Partner (NJSGC)	☐ Add ☐ Remove ☐ Other ☐ Continue	☐ Add ☐ Remove ☐ Other ☐ Continue	☐ Add ☐ Remove ☐ Other ☐ Continue
Name (last, first, MI) L: F: MI:	Name (last, first, MI) L: F: MI:	Name (last, first, MI) L: F: MI:	Name (last, first, MI) L: F: MI:
Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):
☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Social Security Number:	Social Security Number:	Social Security Number:	Social Security Number:

Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name: Policy #: Medicare ID #:	Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name: Policy #: Medicare ID #:	Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name: Policy #: Medicare ID #:	Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name: Policy #: Medicare ID #:
Other Rx Coverage: ☐ Yes ☐ No *If yes:* Payer Name: Policy #: Medicare ID #:	Other Rx Coverage: ☐ Yes ☐ No *If yes:* Payer Name: Policy #: Medicare ID #:	Other Rx Coverage: ☐ Yes ☐ No *If yes:* Payer Name: Policy #: Medicare ID #:	Other Rx Coverage: ☐ Yes ☐ No *If yes:* Payer Name: Policy #: Medicare ID #:
Employed? ☐ Yes ☐ No *If yes, complete Section [F]1*	If last name is different from [Employee's], please explain:	If last name is different from [Employee's], please explain:	If last name is different from [Employee's], please explain:
Home or billing address same as [Employee]? ☐ Yes ☐ No *If NO, complete Section [F]2*	Living with [Employee]? ☐ Yes ☐ No *If NO, complete Section [G]*	Living with [Employee]? ☐ Yes ☐ No *If NO, complete Section [G]*	Living with [Employee]? ☐ Yes ☐ No *If NO, complete Section [G]*

[E.] Additional Spouse/Civil Union Partner/Domestic Partner Information – to be completed by [Employee] If *not applicable, please mark as "NA."*

1. Employer Name:
   Employer Address:
   City, State, Zip Code:
   Employer Phone: ( )

2a.
Street/Apt:
Street/Apt:
City, State, Zip Code:

2b. Please explain why the address is different:

[F.] Additional Child Information – to be completed by [Employee]. *Provide information below about children listed in Section D,* **if** *they have a different address from the employee. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.*

Name(s):
Street/Apt:
Street/Apt:
City, State, Zip Code:
Reason:

Name(s):
Street/Apt:
Street/Apt:
City, State, Zip Code:
Reason:

[G.] Race/Ethnicity – to be completed by the [Employee], at his/her option. *NOTE: your response is appreciated but NOT required!*	*Choose a category that most closely describes you:* ☐ American Indian or Alaskan Native ☐ Black, not of Hispanic origin ☐ Hispanic ☐ Asian or Pacific Islander ☐ White, not of Hispanic origin
[H.] [Employee] Signature	I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I authorize deductions from my earnings for any contributions required from me. Signature: _____ Date: _____
[I.] Over-Age Child's Signature	I represent that all the information supplied in this application regarding the [Dependent Under 31] Continuation Election is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I hereby agree to make contributions required from me for the Dependent Under 31 Continuation Election. Signature: _____ Date: _____
[J.] [Employer] Verification	The requested activity is believed eligible and is approved by the [Employer]. In addition, the [Employer] consents to payroll deduction for Dependent Under 31 Continuation Election: ☐ Yes ☐ No Employer Representative: _____ Date: _____ Representative's Title: _____

INSTRUCTIONS

[Employers] – You must complete the [Employer] Group Information and sections A and [L] in order for this application to be processed.

[Employees] – You must complete sections B through I and submit the signature of each Over-Age Child for which a Dependent Under 31 Continuation Election is made in accordance with Section J in order for this application to be processed.

- Please PRINT except when a signature is requested.
- If a dependent is disabled and you want to continue his or her coverage beyond age 26, you do not have to make a COBRA/NJSGC or Dependent Under 31 election. Instead, select "Other" in Section A3, specify the add/change for disabled dependent and attach proof of disability.
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Qualifying Events

COBRA and NJSGC

C1. Termination of job or reduction in hours
C2. Employee enrollment in Medicare (COBRA only)
C3. Divorce (COBRA/NJSGC); civil union dissolution (NJSGC)
C4. Death of employee
C5. Loss of dependent child status under the plan
C6. Disability (occurring subsequent to another qualifying event)

Dependent Under 31

D1. Loss of dependent status and otherwise eligible
D2. Reestablish eligibility: residency
D3. Reestablish eligibility: nonresident full-time student
D4. Reestablish eligibility: change in marital status
D5. Reestablish eligibility: change in parental status
D6. Reestablish eligibility: termination of other coverage

CONDITIONS OF ENROLLMENT -- [APPLICANT] ACKNOWLEDGEMENTS AND AGREEMENTS

On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer reporting agency, and any employer to give MaxorPlus Ltd, or any consumer reporting agency acting on behalf of MaxorPlus Ltd, information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that MaxorPlus Ltd has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one.
4. I agree MaxorPlus Ltd will provide coverage in accordance with the terms of the contract for the plan.
5. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the plan, if premiums are not paid timely. I authorize my Employer to withhold payments from my wages as contribution to the premium, as appropriate.