



Enrollment Form

TODAY'S DATE:

CLIENT INFORMATION

Rancocas Valley Regional High School

3230

1000-1099, 2000-2099, 3000-3099

CLIENT NAME (PLAN SPONSOR / EMPLOYER)

CLIENT #

GROUP #

CARDMEMBER INFORMATION

FIRST NAME MI LAST NAME ID # SSN#

MAILING ADDRESS CITY STATE ZIP CODE

PHONE NUMBER CELL PHONE EMAIL

COVERAGE TYPE

PLEASE CHECK ONE:

☐

SINGLE

☐

CARDMEMBER/SPOUSE

☐

CARDMEMBER/CHILD

☐

CARDMEMBER/CHILDREN

☐

FAMILY

EFFECTIVE DATE:

REASON CODE

A	NEW ENROLLMENT
B	REINSTATE MEMBER
C	REINSTATE DEPENDENT / SPOUSE
D	ADD DEPENDENT / SPOUSE
E	TERMINATE COVERAGE
F	TERMINATE DEPENDENT COVERAGE
G	NAME CHANGE
H	ADDRESS CHANGE
I	GROUP CHANGE: FROM _____ TO _____

J	RDS ENROLLMENT, APPLICATION NUMBER IF APPLICABLE: _____
K	ISSUE CARD
L	DO NOT ISSUE ID CARD
M	COBRA ENROLLMENT
N	COBRA TERMINATION
O	STUDENT STATUS UPDATE
P	DISABLED DEPENDENT
Q	OVERAGE DEPENDENT**
R	DEPENDENT ADDRESS DIFFERS FROM CARDMEMBER (INCLUDE ON BACK)

ELIGIBILITY

	LAST NAME	FIRST NAME	MI	GENDER	BIRTHDATE	SSN	HICN	REASON CODES
CARDMEMBER								
02 SPOUSE								
EMAIL/PHONE*								
03 DEPENDENT								
EMAIL/PHONE*								
04 DEPENDENT								
EMAIL/PHONE*								
05 DEPENDENT								
EMAIL/PHONE*								
06 DEPENDENT								
EMAIL/PHONE*								
07 DEPENDENT								
EMAIL/PHONE*								
08 DEPENDENT								
EMAIL/PHONE*								

*OPTIONAL, ONLY IF DIFFERENT FROM CARDMEMBER

COORDINATION OF BENEFITS

SECONDARY COVERAGE ID NUMBER INSURANCE COMPANY POLICY / GROUP#

EMPLOYER/PLAN SPONSOR EFFECTIVE DATE

SIGNATURES

MEMBER SIGNATURE

CLIENT SIGNATURE

FOR INTERNAL USE ONLY:

DATE ENTERED: _____

ENTERED BY: _____

LOGGED BY: _____

Back of Enrollment Form

Dependent Address (1)
(if differs from cardmember)

FIRST NAME	MI	LAST NAME	ID #	SSN
MAILING ADDRESS		CITY	STATE	ZIP CODE
PHONE NUMBER		CELL PHONE	EMAIL	

Dependent Address (2)
(if differs from cardmember)

FIRST NAME	MI	LAST NAME	ID #	SSN
MAILING ADDRESS		CITY	STATE	ZIP CODE
PHONE NUMBER		CELL PHONE	EMAIL	

Dependent Address (3)
(if differs from cardmember)

FIRST NAME	MI	LAST NAME	ID #	SSN
MAILING ADDRESS		CITY	STATE	ZIP CODE
PHONE NUMBER		CELL PHONE	EMAIL	

Dependent Address (4)
(if differs from cardmember)

FIRST NAME	MI	LAST NAME	ID #	SSN
MAILING ADDRESS		CITY	STATE	ZIP CODE
PHONE NUMBER		CELL PHONE	EMAIL	

Dependent Address (5)
(if differs from cardmember)

FIRST NAME	MI	LAST NAME	ID #	SSN
MAILING ADDRESS		CITY	STATE	ZIP CODE
PHONE NUMBER		CELL PHONE	EMAIL	

Rancocas Valley Regional High School

Client ID # 3230 Group #: 1000 – 1099

Your Co-Payment Schedule

Retail:

- \$7.50 for a Generic Equivalent Medication
- \$25 for a Brand Name Medication

Mail Order:

- \$7.50 for a Generic Equivalent Medication
- \$25 for a Brand Name Medication

Client ID# 3230 Group #: 2000-2099 (NJ Educators Health Plan)

Your Co-Payment Schedule

Retail:

- \$5 for a Generic Equivalent Medication
- \$10 for a Brand Name Medication

Mail Order:

- \$10 for a Generic Equivalent Medication
- \$20 for a Brand Name Medication

Client ID# 3230 Group #: 3000-3099 (Garden State Plan)

Your Co-Payment Schedule

Retail:

- \$5 for a Generic Equivalent Medication
- \$10 for a Brand Name Medication

Mail Order:

- \$10 for a Generic Equivalent Medication
- \$20 for a Brand Name Medication