BENEFITS ENROLLMENT FORM

PLAN YEAR JULY 1, 2024 - JUNE 30, 2025 | *Employee Class 4-23*

Please visit: www.yalebenefitsnj.com

NEW HIRES: Benefit elections are effective the first of the month following 60 days of employment. You cannot make changes outside of the initial election period or open enrollment unless you experience a qualified life event (e.g. marriage, birth of a baby, etc.) and notify Human Resources within 30 days of the event.

All benefit costs shown below are PER-PAY (SEMI-MONTHLY) PREMIUM COSTS – PER 12-MONTH PERIOD.

EMPLOYEE INFORMATION

Full Name (Please Print)	Date of Birth	Date of Hire

Street Address	City, State, Zip

Primary Phone Number	Social Security Number
( ) -	- -

Email Address	Marital Status
	☐ Single ☐ Married ☐ Divorced ☐ Separated

MEDICAL/PRESCRIPTION DRUG COVERAGE OPTIONS

Premiums Deducted Per-Pay (Semi-Monthly)

Please check (✓) one box.
Medical Coverage includes Prescription Drug Coverage

Coverage Tier	Aetna HNO $20/$40	Aetna QPOS $20/$40*
Employee Only	☐ $159.28 per pay	☐ $15.00 per pay
Employee + Spouse	☐ $897.89 per pay	☐ $490.91 per pay
Employee + Child(ren)	☐ $737.86 per pay	☐ $345.31 per pay
Family	☐ $1,144.11 per pay	☐ $784.40 per pay

*** ALL Enrollees (Employee/Spouse/Child) are REQUIRED to include Primary Care Physician (PCP) Name, Phone Number and Provider ID# if electing the QPOS Plan. To locate the Provider ID# visit www.aetna.com, click "Find a Doctor", then choose "Plan From Employer". Click "Continue as Guest" and enter your Zip Code, and then click "Search". Under "Select a Plan" scroll down to Aetna Open Access, and choose Health Network Option (Open Access), choose "Doctors", then "Primary Care" and the Provider ID will populate.**

PRIMARY PROVIDER ID #: _____ (REQUIRED if electing QPOS plan, failure to provide ID# may result in claims rejection)

☐ **Waive Medical Coverage**

DENTAL COVERAGE

Premiums Deducted Per-Pay (Semi-Monthly)

Please check (✓) one box.

Coverage Tier	Horizon BCBSNJ Dental PPO Access Plan
Employee Only	☐ $5.45 per pay
Employee + Spouse	☐ $11.63 per pay
Employee + Child(ren)	☐ $12.66 per pay
Family	☐ $19.10 per pay

☐ **Waive Dental Coverage**

NOTE: For the coverages listed above, in the event you do not receive a paycheck during a leave of absence or school wide recess in July/August, you will be responsible for remitting your portion of the premium.

DEPENDENT INFORMATION

Dependent Full Name	Relationship	Gender	PCP Provider #	Date of Birth	Social Security Number	Coverage
	☐ Spouse ☐ Child	☐ Male ☐ Female				☐ Medical/Rx ☐ Dental
	☐ Spouse ☐ Child	☐ Male ☐ Female				☐ Medical/Rx ☐ Dental
	☐ Spouse ☐ Child	☐ Male ☐ Female				☐ Medical/Rx ☐ Dental
	☐ Spouse ☐ Child	☐ Male ☐ Female				☐ Medical/Rx ☐ Dental
	☐ Spouse ☐ Child	☐ Male ☐ Female				☐ Medical/Rx ☐ Dental

IF ENROLLING MORE THAN FOUR CHILDREN, PLEASE ATTACH A SEPARATE SHEET OF PAPER WITH THE ABOVE INFORMATION.

MANDATORY SUNLIFE BENEFICIARY DESIGNATION - *3x's Employee Annual Salary with a max of $750,000. YALE pays 100% of this benefit for eligible full-time employees.*

You may designate more than one Primary or Secondary Beneficiary. If you do, make sure to indicate the percentage share each should receive. The total within each class (Primary and Secondary) must equal 100%. If you do not specify percentages, surviving beneficiaries within the class will share proceeds equally.

**** The total within each class (Primary and Secondary) must equal 100%***

Primary Beneficiary(ies)

Name:	Address:	
Social Security Number:	Relationship to Employee:	Percent Share of the Proceeds*:
Name:	Address:	
Social Security Number:	Relationship to Employee:	Percent Share of the Proceeds*:

Secondary (contingent) Beneficiary(ies)

Name:	Address:	
Social Security Number:	Relationship to Employee:	Percent Share of the Proceeds*:
Name:	Address:	
Social Security Number:	Relationship to Employee:	Percent Share of the Proceeds*:

EMPLOYEE AUTHORIZATION

I hereby acknowledge that I cannot change my elections during the plan year, unless there is a qualified change in status under the terms of the plan. I understand that if I am waiving coverage now, I am eligible to enroll in group coverage through Y.A.L.E. during the open enrollment period each year and during the year within 30 days of a qualified change in status.

Employee Signature: _____ Date: _____