



Affirmative Election Form Employees Hired Before 7/1/2020

FAILURE TO COMPLETE & RETURN THIS FORM WILL RESULT IN A CHANGE TO YOUR BENEFITS

Employer Name: Bellmawr Board of Education

EMPLOYEE/PARTICIPANT INFORMATION

Please **PRINT** and fill this section out **COMPLETE**

Social Security #:	Last Name:	First Name:	M.I.:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	Address:		
City:	State:	Zip:	Home Phone #:	Work Phone #:
E-mail:	Effective Date: 1/1/2021			

I understand by signing this form, I choose to stay in my current medical and prescription plans for 1/1/2021. I also understand that I am not able to make any changes to my plans or plan sections until the next open enrollment period, unless I have a qualifying life event.

If you experience a qualifying life event and need to make a change, please contact your personnel department, within 30 days of the event. Examples of a qualifying life event are the following:

- Marriage
- Birth or adoption of a child
- Loss or reduction of coverage for you or your spouse
- Death of a covered dependent
- Divorce

Employee Signature

Print Name: _____

Employee Signature: _____

Date: _____