UNIVERSITY PHYSICIAN
ASSOCIATES OF NEW JERSEY, INC.

THE FACULTY PRACTICE PLAN OF NEW JERSEY MEDICAL SCHOOL

MEMORANDUM

To: UPA & DCMC Employees

From: Donna Sawler, Human Resources

Date: October 4, 2013

Re: Open Enrollment Meeting & Health and Dental Insurance Update

It is time for Open Enrollment for UPA/DCMC's Medical and Dental plans.

Medical (BCBS POS/Direct Access) – I am happy to announce, UPA/DCMC will continue to offer the two existing medical plans without any change to the existing plan design. There will be an increase to the current payroll deduction, therefore, if you are already enrolled or planning to enroll in our medical plan, **it is mandatory to execute a new payroll deduction sheet (attached).**

Dental (Premier, Preferred & Flagship/DeltaCare) – I am happy to announce, UPA/DCMC will continue to offer the three existing dental plans without any change to the existing plan design. There will be a $1.50 increase to the payroll deduction for the DeltaCare/Flagship plan only; therefore, a new payroll deduction sheet must be signed by all existing participants in the Flagship plan.

Given the fact everything is staying the same, this year's meeting is not mandatory. Keep in mind, should you have the desire to join, change from one plan to the other, or add or remove dependents, this is the time to do so and you must fill out a new enrollment form!

Should you join or have a change in plans, please RSVP by calling Extension 2-3672 no later than Monday, October 14, 2013 to attend one of the meetings listed below – lunch will be provided. It is important to bring your Social Security Number and the Social Security Number(s) of any dependent(s) you wish to enroll.

Thursday, October 17, 2013	**12:00 pm SHARP** to 1:00 pm	Medical Science Bldg. MSB B 554
Tuesday, October 22, 2013	**1:00 pm SHARP** to 2:00 pm	Medical Science Bldg. MSB B 554

If you choose to not participate in UPA's medical/dental plans, it is mandatory that you fill out the attached Waiver and a copy of your most recent insurance card. The completed Waiver and card copy should be sent to Human Resources, ADMC 12, Rm. 1201 no later than October 25, 2013. Upon receipt of the completed Waiver, you will be eligible to receive a quarterly payment of $625.00 for this benefit year. These quarterly payments will be taxable to you as compensation. The first check will be distributed, via UPA courier, January 3, 2014. If you do not complete the Waiver, you will not be eligible for the quarterly payment.

Thank you.

w/encl.
BCBS Enrollment form/Medical payroll deduction form
Delta Dental Enrollment form/Dental payroll deduction form
Waiver

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ASSOCIATES OF NEW JERSEY, INC.

THE FACULTY PRACTICE PLAN OF NEW JERSEY MEDICAL SCHOOL

BENEFITS WITHHOLDING AUTHORIZATION

NOVEMBER 2013

In order to participate in the Horizon Blue Cross/Blue Shield Direct Access Plan, I authorize UPA/DCMC to withhold an amount of money from each paycheck based upon the following salary schedule:

Horizon Blue Cross / Blue Shield **Direct Access Buy-Up**				
Salary Range	Single	Husband/Wife	Parent/Child	Family
Under $20,000	$67.53	$132.97	$105.27	$187.16
$20,000 - $29,999	$70.49	$138.87	$107.19	$191.11
$30,000 - $49,999	$71.99	$141.55	$109.20	$195.06
$50,000 - $74,999	$73.45	$144.81	$111.13	$199.08
$75,000 - Over	$74.95	$147.76	$113.14	$204.82

_____ _____

Employee Name Employee Signature

Date: _____, 2013

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THE FACULTY PRACTICE PLAN OF NEW JERSEY MEDICAL SCHOOL

BENEFITS WITHHOLDING AUTHORIZATION

NOVEMBER 2013

In order to participate in the Horizon Blue Cross/Blue Shield POS Plan, I authorize UPA/DCMC to withhold an amount of money from each paycheck based upon the following salary schedule:

Horizon Blue Cross / Blue Shield **POS**				
Salary Range	Single	Husband/Wife	Parent/Child	Family
Under $20,000	$11.89	$23.82	$19.86	$39.64
$20,000 - $29,999	$14.85	$29.72	$21.78	$43.60
$30,000 - $49,999	$16.35	$32.41	$23.79	$47.54
$50,000 - $74,999	$17.82	$35.68	$25.72	$51.57
$75,000 - Over	$19.32	$38.62	$27.73	$57.31

_____ _____

Employee Name Employee Signature

Date: _____, 2013

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Horizon

Horizon Blue Cross Blue Shield of New Jersey

GROUP ENROLLMENT/CHANGE REQUEST

Attn: Large and Mid-Size Group Enrollment
P.O. Box 10168
Newark, NJ 07101-3168
Fax (973) 274-2297
www.HorizonBlue.com

Group Information – to be completed by Employer.

Group Name: _____ Group Number: _____
Sub Group Number: _____
Date of Hire: ____/____/____ Effective Date/Date of Event: ____/____/____
Reason: _____

A. Type of Activity – to be completed by Employer.

Refer to instructions before completing this form. Print clearly.

☐ **ADD** ☐ **REMOVE** ☐ **OTHER CHANGE**

	Effective Date/Date of Event	Reason for Change
☐ Subscriber	____/____/____	
☐ Spouse	____/____/____	
☐ Civil Union Partner (CUP)/Domestic Partner (DP)	____/____/____	
☐ Dependent Child	____/____/____	
☐ Over-Age Child as a Dependent Under 31 *(and complete Coverage Continuation and section B)*	____/____/____	
☐ Name Change	____/____/____	
☐ Change Plan	____/____/____	
☐ Other	____/____/____	
☐ Add/Change Office ID Numbers	____/____/____	
☐ Primary Care Provider	____/____/____	

COVERAGE CONTINUATION

☐ **For Employee**
Date of Loss of Coverage ____/____/____ Qualifying Event #** _____ Date of Qualifying Event ____/____/____
☐ Total Disability* ☐ COBRA/NJSGC Length of Continuation (in months): ☐ 18 ☐ 29
**Attach proof of disability*

☐ **For Spouse/Civil Union Partner*/Domestic Partner**
Date of Loss of Coverage ____/____/____ Qualifying Event #** _____ Date of Qualifying Event ____/____/____
☐ COBRA/NJSGC Length of Continuation (in months): ☐ 18 ☐ 29 ☐ 36
**Civil union partners are eligible to make an election pursuant to NJSGC, if applicable.*

☐ **For Dependent or Over-aged Child**
Date of Loss of Coverage ____/____/____ Qualifying Event #** _____ Date of Qualifying Event ____/____/____
☐ COBRA/NJSGC Length of Continuation (in months): ☐ 18 ☐ 29 ☐ 36
☐ Dependent Under 31 Billing: ☒ Home Home Address: _____
Date of Loss of Coverage ____/____/____ Qualifying Event #** _____ Date of Qualifying Event ____/____/____

Group # _____ Subgroup # _____ ***Qualifying event #s: see list in Instructions.*

B. Additional Information for Dependent Under 31 Continuation Elections.

Provide information below about children listed in Section F for whom a Dependent Under 31 continuation election is being made.

This Continuation Election is being made:

☐ During an Open Enrollment period for the Over-Age Child based on his/her age-out anniversary
☐ Within 30 days prior to the attainment of the limiting age (when the Dependent will become an Over-Age Child)
☐ Within 30 days after the Over-Age Child has established eligibility for a Chapter 375 Continuation Election

C. Employee Information – to be completed by Employee.

☐ **ADD** ☐ **REMOVE** ☐ **CONTINUATION** ☐ **OTHER CHANGE**

If a name change, indicate prior name: _____
Last Name, First Name, M.I. _____
Social Security # _____ Date of Birth ____/____/____ Sex _____
Home Address _____ Apt. _____ City _____ State _____ Zip Code _____
Home Phone _____ E-Mail Address _____
Employer Name _____ Employment Date ____/____/____
Employer Address _____ City _____ State _____ Zip Code _____
Hours Worked Per Week _____ Work Phone _____ E-Mail Address _____
Primary Care Provider Name _____ Current Patient ☐ Yes ☐ No
NPI # _____ Loc Code _____
Other Health Coverage ☐ Yes ☐ No, If Yes, Payer Name _____
Policy # _____ Medicare ID #, If any _____
Previous Coverage ☐ Yes ☐ No, If Yes, Payer Name _____
Policy # _____ Effective Date ____/____/____ Termination Date ____/____/____
Submit a copy of the Certificate of Creditable Coverage

D. 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

E. Plan Option – Your selection must be offered by your employer.

Medical *Check One:*

S	F	2 Adults	PC
☐	☐	☐	☐

☐ Horizon Traditional
☐ Horizon HMO
☐ Horizon POS
☐ Horizon PPO
☐ Horizon Direct Access
☐ Horizon PPO (HRA)
☐ Horizon PPO (HSA)
☐ Horizon Direct Access (HRA)
☐ Horizon Direct Access (HSA)
☐ Horizon EPO
☐ Horizon Advantage EPO

Dental *Check One:*

S	F	2 Adults	PC
☐	☐	☐	☐

☐ Horizon Dental Option Plan
☐ Horizon Dental PPO Plan
☐ Horizon Dental PPO Access Plan

Prescription *Check One:*

S	F	2 Adults	PC
☐	☐	☐	☐

S = Single; F = Family; 2 Adults = Husband/Wife, Civil Union Partners or Domestic Partners; P/C = Parent/Child(ren)

The Employee Copy of this application may be used as a temporary ID card for thirty days from the effective date if authorized by Employer. Coverage must be verified with Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc. prior to visiting a physician or admission to a hospital.

F. Other Individuals Covered – to be completed by 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. Attach proof of disability.

SPOUSE/CUP/DP ☐ **ADD** ☐ **REMOVE** ☐ **CONTINUE SPOUSE (COBRA/NJSGC)**
☐ **CONTINUE CU PARTNER (NJSGC)** ☐ **CONTINUE DP (COBRA/NJSGC)**

Last Name, First Name, M.I. _____

Social Security# _____ Date of Birth ____/____/____ Sex _____

Primary Care Provider Name _____ Current Patient ☐ Yes ☐ No

NPI # _____ Loc Code _____

Other Health Coverage ☐ Yes ☐ No, If Yes, Payer Name _____

Policy # _____ Medicare ID #, If any _____

Previous Coverage ☐ Yes ☐ No, If Yes, Payer Name _____

Policy # _____ Effective Date ____/____/____ Termination Date ____/____/____

Employed? ☐ Yes ☐ No *If Yes, Complete Section G1*

Home or billing address same as Employee? ☐ Yes ☐ No *If No, Complete Section G2*

Submit a copy of the Certificate of Creditable Coverage

1. Child ☐ **ADD** ☐ **REMOVE** ☐ **CONTINUATION** ☐ **OTHER CHANGE**

Last Name, First Name, M.I. _____

Social Security# _____ Date of Birth ____/____/____ Sex _____

Primary Care Provider Name _____ Current Patient ☐ Yes ☐ No

NPI # _____ Loc Code _____

Other Health Coverage ☐ Yes ☐ No, If Yes, Payer Name _____

Policy # _____ Medicare ID #, If any _____

Previous Coverage ☐ Yes ☐ No, If Yes, Payer Name _____

Policy # _____ Effective Date ____/____/____ Termination Date ____/____/____

If last name is different from Employee's, please explain: _____

Living with Employee? ☐ Yes ☐ No *If No, Complete Section H*

Submit a copy of the Certificate of Creditable Coverage

2. Child ☐ **ADD** ☐ **REMOVE** ☐ **CONTINUATION** ☐ **OTHER CHANGE**

Last Name, First Name, M.I. _____

Social Security# _____ Date of Birth ____/____/____ Sex _____

Primary Care Provider Name _____ Current Patient ☐ Yes ☐ No

NPI # _____ Loc Code _____

Other Health Coverage ☐ Yes ☐ No, If Yes, Payer Name _____

Policy # _____ Medicare ID #, If any _____

Previous Coverage ☐ Yes ☐ No, If Yes, Payer Name _____

Policy # _____ Effective Date ____/____/____ Termination Date ____/____/____

If last name is different from Employee's, please explain: _____

Living with Employee? ☐ Yes ☐ No *If No, Complete Section H*

Submit a copy of the Certificate of Creditable Coverage

G. Additional Spouse/CUP/DP Information – to be completed by Employee.

If not applicable mark as N/A.

1. Employer Name _____ Employer Phone _____

Employer Address _____

City _____ State _____ Zip Code _____

2a. Home Address _____

City _____ State _____ Zip Code _____

2b. Please explain why the address is different: _____

H. Additional Child Information – to be completed by Employee.

Provide information below about children listed in Section F, 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 _____

Address _____ Apt _____

City _____ State _____ Zip Code _____

Reason: _____

Name _____

Address _____ Apt _____

City _____ State _____ Zip Code _____

Reason: _____

I. 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: ___/___/___

J. 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 premium payments required from me for the Dependent Under 31 Continuation Election.

Signature: _____ Date: ___/___/___

K. Employer Verification

The requested activity is believed eligible and is approved by the Employer: ☐ Yes ☐ No

Employer Representative: _____ Date: ___/___/___

Representative's Title: _____

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THE FACULTY PRACTICE PLAN OF NEW JERSEY MEDICAL SCHOOL

DELTA DENTAL PLAN

BENEFITS WITHHOLDING AUTHORIZATION

I authorize University Physician Associates/Doctors' Center Management Corporation to withhold the appropriate sum from each paycheck.

PREMIER PLAN	$10.00	_____
PREFERRED PLAN	$6.00	_____
DELTACARE PLAN	$5.50	_____

EMPLOYEE NAME (print)_____

EMPLOYEE SIGNATURE_____

DATE: _____

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DENTAL ENROLLMENT FORM

Eight Digit Group Number

☐ Delta Dental Premier® _____ - _____

☐ Delta Dental Premier®/Advantage Program _____ - _____

☐ Delta Dental PPO℠ plus Premier Program _____ - _____

☐ Delta Dental PPO℠ _____ - 6_____

☐Advantage Program _____ - 8_____

☐DeltaCare® _____ - 9_____

Name of Employer	Effective Date of Coverage

GENERAL INFORMATION - THIS SECTION MUST BE COMPLETED - PLEASE PRINT CLEARLY

Name (Last) (First) (Middle)	Date of Birth	Social Security Number
	_____/_____/_____	___ ___ ___ - ___ ___ - ___ ___ ___ ___

Street Address	City, State, Zip	County

Date of Employment	Type of Coverage	Marital Status	Home Telephone
_____/_____/_____	☐ Single ☐ Parent/Child ☐ Husband/Wife ☐ Parent/Children ☐ Family	☐Single ☐Married ☐Divorced/Separated	( )

Enrollment	First Name - Last Name	Social Security Number	Date of Birth	Full-Time Student
Subscriber		_____ - _____ - _____	/ /	
Spouse*		_____ - _____ - _____	/ /	
Dependent		_____ - _____ - _____	/ /	☐ Yes ☐ No
Dependent		_____ - _____ - _____	/ /	☐Yes ☐No
Dependent		_____ - _____ - _____	/ /	☐Yes ☐No
Dependent		_____ - _____ - _____	/ /	☐Yes ☐No

* If spouse has other dental coverage, please list name and address of employer and other carrier:

If choosing DeltaCare, you must complete this section

	Choice of Dentist	Office Number	For Delta Use Only
1			
2			
3			

Optional choices will be selected if a provider terminates his/her participation agreement with Flagship. I authorize the release to Flagship Dental Plans of all my treatment information as a DeltaCare subscriber and the treatment information of my dependent(s). I understand that I may change my primary Plan Participating Dentist by calling or in writing provided that a request for such change is received by Flagship at least thirty (30) days prior to the new contract month. Request received by the tenth (10th) of the month will be effective the first (1st) of the following month.

I hereby represent that all information furnished is true and complete to the best of my knowledge and authorize my employer to make any required deduction from my wages.

_____ _____

Subscriber Signature Date

Delta Use Only

_____

Entered

_____

Operator #

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THE FACULTY PRACTICE PLAN OF NEW JERSEY MEDICAL SCHOOL

WAIVER

EMPLOYER HEALTH BENEFITS COVERAGE

MEDICAL:

Employee Name_____

Policy Holder Name_____

Group Policy No._____

Marital Status: Single___ Married___ Widowed___ Divorced___

I have been given the opportunity to enroll in University Physician Associates/Doctor's Center Management Corporation's group health plan. I refuse the following:

___Employee, Spouse and Child coverage
___Spouse Coverage
___Child Coverage

Reason for refusal (Please check all appropriate boxes)

___other group coverage sponsored by spouse's employer
___other group coverage sponsored by another organization
___other reason (please explain)

_____

CARRIER NAME: _____
POLICY NUMBER:_____

DENTAL:

____I am also choosing to waive Dental Coverage

I understand that if I later wish to enroll for any of the coverage(s) refused, I will be required to submit an Enrollment Form and coverage may be subject to a pre-existing conditions exclusion.

Employee Signature_____ Date_____
Witness Signature_____ Date_____

A.B. 3/11

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