# Enrollment Form

Name of Association and/or group (employer): NJSFAC

Member/Employee last name, first name, middle initial:_____

Address of Member/Employee_____

Email_____Phone Number_____

Social Security Number: _____

Gender: ☐ male ☐ female Effective Date_____

Date of birth (month/date/year): _____

Type of coverage selected:
- ☐ member/employee only
- ☐ member/employee and one dependent
- ☐ member/employee and children
- ☐ member/employee and family
- ☐ waive coverage

*** Dependent Relationship**: S=spouse, C=child, H=handicapped child, T=student

| dependent last name | dependent first name | gender | * Dependent Relationship | date of birth mm/dd/yyyy |
|---|---|---|---|---|
| | | | ☐S ☐C ☐H ☐T | / / |
| | | | ☐S ☐C ☐H ☐T | / / |
| | | | ☐S ☐C ☐H ☐T | / / |
| | | | ☐S ☐C ☐H ☐T | / / |
| | | | ☐S ☐C ☐H ☐T | / / |

Employee Signature: _____

Please return this form to the benefit administrator:

Bollinger, Inc. 400 Market Street, Suite 450, Philadelphia, PA 19106

Phone: 800-952-4050 Fax: 215-351-9012