BeneCard PBF
Prescription Benefit Facilitator

Enrollment Form

TODAY'S DATE:

CLIENT INFORMATION

Lumberton Township Board of Education #3116

CLIENT NAME (PLAN SPONSOR / EMPLOYER) CLIENT # GROUP # (select from last page)

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: EFFECTIVE DATE:

☐ SINGLE ☐ CARDMEMBER/SPOUSE ☐ CARDMEMBER/CHILD ☐ CARDMEMBER/CHILDREN ☐ FAMILY

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 CARMEMBER

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:_____

3131 Princeton Pike, Bldg. 2B, Suite 103, Lawrenceville, NJ 08648 Fax: 609-219-1660 eligibility@benecard.com www.benecardpbf.com

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

Benecard Group #s	Medical Plan Name w/ Corresponding Rx
Group # 1000	**Pairs w/ Medical Plan:** • Aetna Choice POS II 15/25 Copay **Prescription Retail Copays (7/16/35)**
Group # 2000	**Pairs w/ Medical Plans:** • Aetna Choice POS II 20/30 Copay • Aetna QPOS 20 Copay **Prescription Retail Copays (3/18/46)**
Group # 3000	**Pairs w/ Medical Plans:** • Aetna Choice POS II 20/35 Copay • Aetna QPOS 20/35 **Prescription Retail Copays (7/21)**
Group # 4000	**Pairs w/ Medical Plans:** • Aetna Choice POS II 10 Copay • Aetna Choice POS II 15 Copay • Aetna QPOS 10 Copay **Prescription Retail Copays (3/10)**