



EB EMPLOYEE SOLUTIONS, LLC.

# ENROLLMENT FORM

EMPLOYER NAME:  
Hammonton Board of Education

PLAN OPTION (if applicable):

### EMPLOYEE INFORMATION

EMPLOYEE NAME (First, Middle, Last):

EMPLOYEE ADDRESS (Line 1):

EMPLOYEE ADDRESS (Line 2):

CITY, STATE, ZIP CODE:

SOCIAL SECURITY NUMBER:\*

GENDER:

DATE OF BIRTH (MM/DD/YYYY):

E-MAIL ADDRESS:

### DEPENDENT INFORMATION

SPOUSE	FIRST NAME	MIDDLE INITIAL	LAST NAME
	DATE OF BIRTH (MM/DD/YYYY):	SOCIAL SECURITY NUMBER:*	GENDER:
DEPENDENT CHILD FULL TIME STUDENT?	FIRST NAME	MIDDLE INITIAL	LAST NAME
YES <input type="checkbox"/> NO <input type="checkbox"/>	DATE OF BIRTH (MM/DD/YYYY):	SOCIAL SECURITY NUMBER:*	GENDER:
DEPENDENT CHILD FULL TIME STUDENT?	FIRST NAME	MIDDLE INITIAL	LAST NAME
YES <input type="checkbox"/> NO <input type="checkbox"/>	DATE OF BIRTH (MM/DD/YYYY):	SOCIAL SECURITY NUMBER:*	GENDER:
DEPENDENT CHILD FULL TIME STUDENT?	FIRST NAME	MIDDLE INITIAL	LAST NAME
YES <input type="checkbox"/> NO <input type="checkbox"/>	DATE OF BIRTH (MM/DD/YYYY):	SOCIAL SECURITY NUMBER:*	GENDER:
DEPENDENT CHILD FULL TIME STUDENT?	FIRST NAME	MIDDLE INITIAL	LAST NAME
YES <input type="checkbox"/> NO <input type="checkbox"/>	DATE OF BIRTH (MM/DD/YYYY):	SOCIAL SECURITY NUMBER:*	GENDER:

I hereby attest to agree to all the terms and conditions in association with the Difference Card. I understand that upon the Difference Card being lost or stolen, I will notify my Human Resource department within 24 hours. Upon termination, I agree to return the difference card within one (1) business day.

EMPLOYEE SIGNATURE

DATE (MM/DD/YYYY):

\*Due to Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (PL 110 173), social security numbers must be included or the form will be returned.

EFFECTIVE DATE (MM/DD/YYYY):

ACTIVE  COBRA   
(please check one)

PLAN OPTION (if applicable):

APPROVED BY

DATE (MM/DD/YYYY):