Insurance Administrator of America, Inc.
1934 Olney Avenue, Suite 200 Cherry Hill, NJ 08003
(p) 856-470-1200 · (f) 800-238-0519

The City of Hoboken - IAA Member Enrollment Form

Group # 1815

☐ New Hire ☐ Change Request	Location:	Job Title:	☐ Salary ☐ Hourly
Date of Hire:	Effective Date:	Dept.	SSN#:
Last Name:	First Name:	MI:	Date of Birth:
Street Address:			Gender: ☐ M ☐ F
City:	State:	Zip:	Other Insurance: ☐ Yes ☐ No
Home Phone:	Email:	Marital Status: ☐ Single ☐ Married ☐ Divorced	

Dependent Information
Please complete all fields, if more space is needed use the back of this form. If you are waiving all coverage, Dependent Information is not required.

Last Name	First Name	MI	Social Security #	Date of Birth	Gender	Other Insurance
					☐ M ☐ F	☐ Yes ☐ No
					☐ M ☐ F	☐ Yes ☐ No
					☐ M ☐ F	☐ Yes ☐ No
					☐ M ☐ F	☐ Yes ☐ No
					☐ M ☐ F	☐ Yes ☐ No
					☐ M ☐ F	☐ Yes ☐ No

BENEFIT PLAN OPTIONS	**COVERAGE LEVEL**
☐ Active Plan ☐ Retiree Plan ☐ Retiree Plan with Rx	☐ EMPLOYEE ONLY ☐ EMPLOYEE + CHILD(REN) ☐ EMPLOYEE + SPOUSE ☐ FAMILY

Benefit Plan Waiver ☐ WAIVING COVERAGE – Reason for refusal (please check all appropriate boxes):

☐ Other coverage sponsored by my employer ☐ Group coverage sponsored by my spouse's employer ☐ Group coverage sponsored by another organization
☐ Other reasons (please explain): Please provide name of carrier and your policy number:

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Other Insurance If you answered "Yes" above for you or any of your dependents complete this section. If more space is needed use the back of this form.		
Name of covered individual:	Name of employer:	
Insurance Carrier:	Policy Number:	Is this plan Primary: ☐ Yes ☐ No
Address:	Phone Number:	
I hereby waive coverage in the Health Plan offered to me by my employer, I understand that I will not have an opportunity to enroll in the Group Health Plan until the next open enrollment period or unless I experience a Life Status changing event. Employee Signature _____ Date		
My signature below is confirmation that I have elected the Group Health Plan offered to me by my employer as indicated above. I understand that my contributions through payroll deduction are voluntary and in compliance with Federal Regulations and State Laws. I further understand that I cannot change my elections until the next open enrollment period or unless I experience a Life Status change. As Plan administrator, Insurance Administrator of America, Inc. is authorized to obtain necessary personal medical information in accordance with the Health Insurance Portability and Accountability Act (HIPAA) in order to administer the Group Health Plan in which I participate. Employee Signature _____ Date		

Employer Section - *Eligibility Verification*

Required Forms	☐ Copy Attached ☐ Copy Requested ☐ No Prior Coverage	Date Completed:
I verify to the best of my knowledge that the information provided herein is accurate. Employer Signature _____ Date		