New Jersey – Member Enrollment/Change Request Form

UnitedHealthcare®

Group Information – To be completed by Employer:

Group Name:	Group Number:	Contract Specific Package:

A. Type of Activity – To be completed by Employer. *Refer to instructions on page 4 before completing this form. Print clearly.*

	Activity – Check all that apply	Effective Date/ Date of Event	Date of Hire/Reason for Change
1. ADD	☐ Enrollment of a new Subscriber		Date of Hire:
	☐ Add Spouse		
	☐ Add Civil Union Partner		
	☐ Add Domestic Partner		
	☐ Add Dependent Child		
	☐ Add Over-Age Child as a Dependent Under 31 *(and complete section A 4)*		
2. REMOVE	☐ Employee Withdrawal/Termination		
	☐ Remove Spouse		
	☐ Remove Civil Union Partner		
	☐ Remove Domestic Partner		
	☐ Remove Dependent Child		
	☐ Remove Over-Age Child as a Dependent Under 31		
3. OTHER CHANGE	☐ Name Change		
	☐ Change Plan		
	☐ Other		
	☐ Add/Change Office ID Numbers: Primary/OB/Gyn		

4. COVERAGE CONTINUATION

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

Attach proof of disability.

☐ For Spouse/Civil Union Partner*/Domestic Partner
- Length of Continuation (in months):
- ☐ 18 ☐ 36
- Date of Loss of Coverage: ___ ___ ___
- Qualifying Event: _____ **
- Date of Qualifying Event: ___ ___ ___

Civil union partners are eligible to make an election pursuant to NJSGC, if applicable.

☐ For Dependent or Over-age Child
- ☐ COBRA/NJSGC
  - Length of Continuation (in months):
  - ☐18 ☐36
  - Loss of Coverage: ___ ___ ___
  - Qualifying Event #: _____ **
  - Date: ___ ___ ___
- ☐ Dependent Under 31
  - Qualifying Event #: _____ **

***Qualifying event #s: see list in Instructions*

B. Employee Information – To be completed by the Employee

Name (Last, First, MI):	SSN:	Birthdate (mm/dd/yyyy):	
Londinski	220630132	01/30/2000	☐ Male ☐ Female

HOME

Street/Apt: 10 Esther Court

Street/Apt:

City: Lakewood State: NJ Zip Code: 08701

Preferred Phone: ☐Home ☑Cell ☐Work 732-604-9547 Alternate Phone: ☐Home ☐Cell ☐Work

Email: clondinski1234@gmail.com

WORK

Employer Name: Kenover Marketing

Address: 72 New Hook Rd

City: Bayonne State: NJ Zip Code: 07002

Phone: (718) 369-4600 Email:

Employment Date: ___ ___ ___

Hours worked per week: ___

B. Employee Information – To be completed by the Employee (continued)

ACTIVITY

☐ Add ☐ Remove ☐ Continuation ☐ Other Change *If a name change, indicate prior name:*

Primary Name:	Provider #:	Current Patient: ☐Yes ☐No
Ob/Gyn Name:	Provider #:	Current Patient: ☐Yes ☐No

Other Health Coverage? ☐ Yes ☑ No

If yes: Payer Name: _____ Policy #: _____

Medicare ID#, if any: _____

C. Plan Option - To be completed by the Employee

Medical Plan: ☐ Managed Indemnity ☐ Options PPO ☐ Other Plan _____ ☐ Choice Plus Insurance ☐ Select HMO

D. Other Individuals Covered - To be completed by the 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.*

1. ☑ Spouse ☐ Domestic Partner(DP) ☐ Civil Union (CU) Partner	2. Child	3. Child	4. Child
☑ Add ☐ Remove ☐ Other ☐ Continue Spouse ☐ Continue Civil Union Partner (NJSGC) ☐ Continue Domestic Partner (NJSGC)	☑ Add ☐ Remove ☐ Other ☐ Continue	☐ Add ☐ Remove ☐ Other ☐ Continue	☐ Add ☐ Remove ☐ Other ☐ Continue
Name (last, first, MI) L: Londinski F: Rachel MI: n/a	Name (last, first, MI) L: Londinski F: Hadassa MI: n/a	Name (last, first, MI) L: F: MI:	Name (last, first, MI) L: F: MI:
Birthdate (mm/dd/yyyy): 08/04/2001	Birthdate (mm/dd/yyyy): 11/07/2023	Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):
☐ Male ☑ Female / ☐ Disabled	☐ Male ☑ Female / ☐ Disabled	☐ Male ☐ Female / ☐ Disabled	☐ Male ☐ Female / ☐ Disabled
Social Security Number: 051 92 3189	Social Security Number:	Social Security Number:	Social Security Number:
Other Health Coverage: ☐Yes ☑ No *If yes:* Payer Name: Policy#: Medicare ID#:	Other Health Coverage: ☐Yes ☑ No *If yes:* Payer Name: Policy#: Medicare ID#:	Other Health Coverage: ☐Yes ☐ No *If yes:* Payer Name: Policy#: Medicare ID#:	Other Health Coverage: ☐Yes ☐ No *If yes:* Payer Name: Policy#: Medicare ID#:
Primary Care Provider: Name: Lakewood Medical Associates Provider ID#: Current Patient? ☑Yes ☐ No	Primary Care Provider: Name: Kinder Pediatrics Provider ID#: Current Patient? ☑Yes ☐ No	Primary Care Provider: Name: Provider ID#: Current Patient? ☐Yes ☐ No	Primary Care Provider: Name: Provider ID#: Current Patient? ☐Yes ☐ No
OB/Gyn: Name: Sunrise OBGYN Provider ID#: Current Patient? ☑Yes ☐ No	OB/Gyn: Name: Provider ID#: Current Patient? ☐Yes ☐ No	OB/Gyn: Name: Provider ID#: Current Patient? ☐Yes ☐ No	OB/Gyn: Name: Provider ID#: Current Patient? ☐Yes ☐ No
Employed? ☑Yes ☐ No *If Yes, complete Section E1*	If last name is different from Employee's, please explain:	If last name is different from Employee's, please explain:	If last name is different from Employee's, please explain:
Home or billing address same as Employee? ☑Yes ☐ No *If No, complete Section E2*	Living with Employee ☑Yes ☐ No If No, complete Section F	Living with Employee ☐Yes ☐ No If No, complete Section F	Living with Employee ☐Yes ☐ No If No, complete Section F

E. Additional Spouse/Civil Union Partner/Domestic Partner Information - To be completed by the Employee. *If not applicable, please mark as "NA".*

1.

Employer Name: Lion Health System

Employer Address: 850 Towbin Rd

City, State, Zip Code: Lakewood, NJ 08701 Employer Phone: 732-714-5551

2a.

Street/Apt:

Street/Apt:

City, State, Zip Code:

2b. Please explain why the address is different:

F. Additional Child Information - To be completed by the Employee. *Provide information below about children listed in Section D,* **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(s):
Street/Apt:
Street/Apt:
City, State, Zip Code:
Reason:

Name(s):
Street/Apt:
Street/Apt:
City, State, Zip Code:
Reason:

G. 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

H. 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: Yechezkel Londinski Date: 12/17/2025

I. 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 contributions required from me for the Dependent Under 31 Continuation Election.

Signature: Date:

J. Employer Verification

The requested activity is believed eligible and is approved by the Employer.

Employer Representative: Date:

Representative's Title:

INSTRUCTIONS

Employers – You must complete the Employer Group Information and sections A and J in order for this application to be processed.

Employees – You must complete sections B through H and submit the signature of each Over-Age Child for which a Dependent Under 31 Continuation Election is made in accordance with Section I in order for this application to be processed.

- Please PRINT except when a signature is requested.
- If a dependent is disabled and you want to continue his or her coverage beyond age 26, you do not have to make a COBRA/NJSGC or Dependent Under 31 election. Instead, select "Other" in Section A3, and attach proof of disability.
- For provider addresses, include the zip code plus the four digit extension (11 digits)
- You can obtain the providers' correct names and addresses from the appropriate provider directory. You may also obtain each provider's NPI number from the provider directory or by contacting the provider directly. Providers with multiple office locations and individual providers who belong to more than one practice or provider entity may have more than one NPI number. You should confirm the correct NPI number for the specific provider and office location where you will be seen by contacting that office directly.

QUALIFYING EVENTS

COBRA and NJSGC

C1. Termination of job or reduction in hours
C2. Employee enrollment in Medicare (COBRA only)
C3. Divorce (COBRA/NJSGC); civil union dissolution (NJSGC)
C4. Death of employee
C5. Loss of dependent child status under the plan
C6. Disability (occurring subsequent to another qualifying event)

Dependent Under 31

D1. Loss of dependent status and otherwise eligible
D2. Reestablish eligibility: residency
D3. Reestablish eligibility: nonresident full-time student
D4. Reestablish eligibility: change in marital status
D5. Reestablish eligibility: change in parental status
D6. Reestablish eligibility: termination of other coverage

CONDITIONS OF ENROLLMENT – APPLICANT ACKNOWLEDGEMENTS AND AGREEMENTS

On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer reporting agency, and any employer to give UnitedHealthcare Insurance Company or any consumer reporting agency acting on behalf of UnitedHealthcare Insurance Company information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that UnitedHealthcare Insurance Company has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one.
4. I agree UnitedHealthcare Insurance Company will provide coverage in accordance with the terms of the contract for the group policy.
5. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the group policy if premiums are not paid timely. I authorize my Employer to withhold payments from my wages as contribution to the premium, as appropriate.

Flex Facts Enrollment Form

Please return this form to your human resources representative

Personal Information

Employer: Kenover Marketing

Full Name: Londinski (Last) Yechezkel (First) D (M.I.)

Address: 10 Esther Court (Street Address) (Apartment/Unit #)

Lakewood (City) NJ (State) 08701 (ZIP Code)

Phone: 732-604-9547 Social Security Number: 220630132

Birth Date: 01/30/2000 E-mail Address: clondinski1234@gmail.com

Effective Date: 01/01/2026 Plan Year Start: 2026

Benefit Election

I ELECT THE FOLLOWING:	Amount Per Pay Period	# of Pay Periods	Annual Election
☐ Medical FSA Account	$		$
☑ Dependent Care Account	$ 62.5	52	$ 3,250
☐ Limited Purpose FSA (HSA only)	$		$
☐ Transit Account	Monthly Election: $		

Frequency of Pay: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other

Date of First Deduction: _____

Spouse or Dependent Card Information

Full Name: Londinski (Last) Rachel (First) (M.I.)

Mail Card to: ☑ Address listed above ☐ Alternate Address: 10 Esther Court (Street Address) (Apt. /Unit #)

Date of Birth: 08/04/2001

Lakewood (City) NJ (State) 08701 (ZIP Code)

Soc. Sec. Number: 051923189 Relationship: spouse

Employee Authorization

- If this form is not returned to your employer by your effective date, you will not be able to participate in the plan until the following plan year.
- Your accounts will not automatically renew. You must sign a new election form each year at open enrollment.
- You cannot change the FSA election during the plan year unless you have an eligible change in status.
- This agreement is subject to the terms of the company's Flexible Benefits Plan.
- By signing this form, I agree that my cash compensation will be redirected by the amounts set forth above.

Signature: Yechezkel Londinski Date: 12/17/2025

Flex Facts | 1200 River Avenue, Suite 10E | Lakewood, NJ 08701 | www.flexfacts.com | 877-94-FACTS