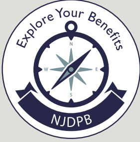
HD-0961-0519



State Health Benefits Program (SHBP) • School Employees' Health Benefits Program (SEHBP)

RETIREE DENTAL PLAN APPLICATION

1. EMPLOYEE INFORMATION — Last Name First MI

Gender	Birth Date	Social Security Number	Marital Status*
	/ /	— —	

Telephone Number	Personal Email Address
( )	

Home Address No. and Street Name

City State Zip

2. FORMER EMPLOYER NAME

____

DATE OF RETIREMENT _______/_______/_______

Were you a part-time employee when you retired? ☐ Yes ☐ No

3. PREVIOUS DENTAL COVERAGE

Were you enrolled in a group dental plan for at least 12 months prior to now? ☐ No ☐ Yes If yes, provide the previous Dental Plan Name

____

4. TYPE OF ACTIVITY *(check one)*

☐ New Retiree
☐ Dental Plan Change
☐ Enrolling in Dental *(Previously Waived)*
☐ Adding Dependents
☐ Deleting Dependents
☐ Survivor Enrollment Decedents SS#_________________________

Reason ____

Date of Event ______/______/______

5. LEVEL OF MEDICARE COVERAGE

Do you have Medicare Part A ? (Hospital Insurance)	☐ Yes	☐ No
Do you have Medicare Part B ? (Medical Insurance)	☐ Yes	☐ No
Does your spouse/partner have Medicare Part A ?	☐ Yes	☐ No
Does your spouse/partner have Medicare Part B ?	☐ Yes	☐ No
Does your child have Medicare ?	☐ Yes	☐ No

Anyone eligible for Medicare (age 65 or older or in receipt of Social Security Disability benefit(s) for at least 24 months) must be enrolled under both Medicare Part A (Hospital) and Part B (Medical) in order to continue coverage under this program. If enrolled, a photocopy of the Medicare card must be submitted with this application.

6. LEVEL OF COVERAGE

☐ Single ☐ Parent/Child ☐ Member/Spouse/Civil Union ☐ Member/Domestic Partner ☐ Family

7. DENTAL PLAN You must remain enrolled in selected plan for 12 months.

I wish to be covered under a Dental Plan Organization (DPO)* ☐ Cigna ☐ MetLife ☐ Healthplex ☐ Horizon BCBSNJ ☐ Aetna DMO

Dentist ID Number _______________________________________

☐ I wish to be covered under the Dental Expense Plan (Aetna DEP)*

8. DEPENDENT INFORMATION: List all eligible dependents and attach required proof of dependency documents.*

☐ **Additional sheets attached. Any dependents not listed will be removed.**

Eligible Dependents Last Name, First Name	Social Security No.	Circle Relationship	Birth Date	Gender
	— —	Spouse / Civil Union / Domestic Partner	/ /	
	— —	Child *(Natural, Adopted, Foster, Step, Legal Ward)*	/ /	
	— —	Child *(Natural, Adopted, Foster, Step, Legal Ward)*	/ /	

***See Instructions page for detailed information and Mailing Address**

FOR DIVISION USE ONLY

Event Reason: ☐

Effective Date ______/______/______

Location No. ☐☐☐☐ ☐☐

EMPLOYEE CERTIFICATION — I certify that all the information supplied on this form is true to the best of my knowledge and that it is verifiable. I understand that if I waive my right to coverage at this time, enrollment is not permissible unless other coverage is lost and proof of loss is provided (HIPAA). I understand that I must remain enrolled in the Dental Plan for a minimum of 12 months and that there is no guarantee of continuous participation by dental service providers, either dentists or facilities, in the DPO plans. If either my dentist or dental center terminates participation in my selected plan, I must select another dentist or dental center participating in that plan to receive the "in-network" benefit. I authorize any hospital, physician, dentist or dental care provider to furnish my dental plan or its assignee with such dental information about myself or my covered dependents as the assignee may require. **Misrepresentation:** Any person that knowingly provides false or misleading information is subject to criminal and civil penalties.

9. Employee Signature: ____ **Date:** ______/______/______

INSTRUCTIONS FOR THE NEW JERSEY EMPLOYEE DENTAL PLANS ENROLLMENT and/or CHANGE FORM

SECTION 1 – **EMPLOYEE INFORMATION** – Complete entire section. **Indicate Marital Status** as follows: **S** (Single), **M** (Married), **CU** (Civil Union), **DP** (Domestic Partner), **D** (Divorced), **W** (Widowed)

SECTION 2 – Indicate your former employers name, your date of retirement and if you were a part-time employee when you retired.

SECTION 3 – PREVIOUS DENTAL COVERAGE – Indicate whether you were enrolled in a group dental plan for 12 months preceding your retirement date. If you were not, you will be enrolled in Tier 1 of the dental plan you select.

SECTION 4 – TYPE OF ACTIVITY – indicate by checking the appropriate block.

SECTION 5 – LEVEL OF MEDICARE COVERAGE – Indicate whether you and/or your spouse/partner and/or child are enrolled in Medicare Parts A and B by checking the appropriate block(s). Anyone eligible for Medicare (age 65 or older or in receipt of Social Security Disability benefit(s) for at least 24 months) must be enrolled under both Medicare Part A (Hospital) and Part B (Medical) in order to continue coverage under this program. If enrolled, a photocopy of the Medicare card must be submitted with this application.

SECTION 6 – LEVEL OF COVERAGE – indicate by checking the appropriate block.

SECTION 7 – DENTAL PLAN – Select only one plan. The *Employee Dental Plans Member Guidebook* provides you with all available options at ***www.nj.gov/treasury/pensions*** If you enroll in a Dental Plan Organization (DPO), you must receive services from an in-network dentist in order to have your claims paid. You must select a participating dentist within the DPO, ensuring the dentist or facility takes new patients and participates with the Employee Dental Plans. If you enroll in the Dental Expense Plan (Aetna DEP), you may receive services from any dentist. You will be required to pay up front for covered services until a deductible is met.

Note: After you enroll in a dental plan, you must remain enrolled for 12 months until you are permitted to terminate coverage or change plans.

SECTION 8 – DEPENDENT INFORMATION – List all eligible dependents and attach dependent documentation proof (see attached). If proper documentation has already been provided and approved, do not resubmit. If appropriate dependent documentation proof is not provided, dependents may not be enrolled. Ensure your dependents match your level of coverage (Section 4). Your child(ren) may be covered until the end of the calendar year they turn 26. Any dependents not listed will not be covered. Attach extra pages for additional dependents.

SECTION 9– EMPLOYEE SIGNATURE – Read, sign, date, and attach required dependent documentation. If additional sheets are submitted with the application, check box indicating such.

MISREPRESENTATION: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties.

MAIL COMPLETED APPLICATION TO: **New Jersey Division of Pensions & Benefits (NJDPB)**
Health Benefits Bureau
P.O. Box 299
Trenton, NJ 08625-0299

HB-0840-1217

State Health Benefits Program (SHBP) • School Employees' Health Benefits Program (SEHBP)

REQUIRED DOCUMENTATION FOR DEPENDENT ELIGIBILITY AND ENROLLMENT

The State Health Benefits Program (SHBP) and School Employees' Health Benefits Program (SEHBP) are required to ensure that only employees, retirees, and eligible dependents are receiving health care coverage under the Programs. The New Jersey Division of Pensions & Benefits (NJDPB) must guarantee consistent application of eligibility requirements within the plans. Employees or retirees who enroll dependents for coverage (spouses, civil union partners, domestic partners, children, disabled and/or overage children continuing coverage) MUST submit the following documentation in addition to the appropriate health benefits enrollment or change of status application. If proper documentation has already been provided and approved, do not resubmit. If appropriate dependent documentation proof is not provided, dependents may not be enrolled. **ANY DEPENDENTS NOT LISTED ON THE APPLICATION WILL NOT BE COVERED.**

DEPENDENTS	ELIGIBILITY DEFINITION	DOCUMENTATION REQUIRED
SPOUSE	A person to whom you are legally married.	A copy of the marriage certificate **and** a copy of the front page of the employee/retiree's federal tax return* (Form 1040) from last year that includes the spouse. If filing separately, submit a copy of both spouses' tax returns that list the same address. If marriage occurred in the current calendar year, a copy of the tax return is not required. **Or**, if tax return is not available, provide a copy of a bank statement or bill (dated within 90 day of the application) that includes the names of both spouses and is received at the same address.
CIVIL UNION PARTNER	A person of the same sex with whom you have entered into a civil union.	A copy of the marriage certificate **and** a copy of the front page of the employee/retiree's federal tax return* (Form 1040) from last year that includes the partner. If filing separately, submit a copy of both partners' tax returns that list the same address. If marriage occurred in the current calendar year, a copy of the tax return is not required. **Or**, if tax return is not available, provide a copy of a bank statement or bill (dated within 90 day of the application) that includes the names of both partners and is received at the same address.
DOMESTIC PARTNER	A person of the same sex with whom you have entered into a domestic partnership. Under P.L. 2003, c. 246, the Domestic Partnership Act, health benefits coverage is available to domestic partners of State employees, State retirees, or employees or retirees of a SHBP - or SEHBP - participating local public entity that has adopted a resolution to provide Chapter 246 health benefits.	A copy of the New Jersey certificate of domestic partnership dated prior to February 19, 2007, or a valid certification from another State or foreign jurisdiction that recognizes same-sex domestic partners **and** a copy of the front page of the employee/retiree's N.J. tax return* from last year that includes the partner. If filing separately, submit a copy of both partners' NJ tax returns that list the same address. If Domestic Partnership occurred in the current calendar year, a copy of the tax return is not required. **Or**, if tax return is not available, provide a copy of a bank statement or bill (dated within 90 days of the application) that includes the names of both partners and is received at the same address.
CHILDREN	A subscriber's child until age 26, regardless of the child's marital, student, or financial dependency status – even if the young adult no longer lives with his or her parents. This includes a stepchild, foster child, legally adopted child, or any child in a guardian-ward relationship upon submitting required supporting documentation.	**Natural or Adopted Child** – A copy of the child's birth certificate showing the name of the employee/retiree as a parent. **Step Child** – A copy of the child's birth certificate showing the name of the employee/retiree's spouse or partner as a parent **and** a copy of the marriage/partnership certificate showing the names of the employee/retiree and spouse/partner. **Legal Guardian, Grandchild, or Foster Child** – Copies of final court orders with the presiding judge's signature and seal. Documents must attest to the legal guardianship by the employee.
DEPENDENT CHILDREN WITH DISABILITIES	If a covered child is not capable of self-support when he or she reaches age 26 due to mental illness or incapacity, or a physical disability, the child may be eligible for a continuance of coverage. Coverage for children with disabilities may continue only while (1) you are covered through the SHBP/SEHBP; (2) the child continues to be disabled; (3) the child is unmarried or does not enter into a civil union or domestic partnership; and (4) the child remains substantially dependent on you for support and maintenance. You may be contacted periodically to verify that the child remains eligible for coverage.	Documentation for the appropriate "child" type (as noted above) **and** a copy of the front page of the employee/retiree's federal tax return* (Form 1040) from last year that includes the child. If Social Security disability has been awarded, or is currently pending, please include this information with the documentation that is submitted. Please note that this information is only verifying the child's eligibility as a dependent. The disability status of the child is determined through a separate process.
CONTINUED COVERAGE FOR OVERAGE CHILDREN	Certain children over age 26 may be eligible for continued coverage until age 31 under the provisions of P.L. 2005, c. 375. This includes a child by blood or law who: (1) is under the age of 31; (2) is unmarried or not a partner in a civil union or domestic partnership; (3) has no dependent(s) of his or her own; (4) is a resident of New Jersey or is a student at an accredited public or private institution of higher education, with at least 15 credit hours; and (5) is not provided coverage as a subscriber, insured, enrollee, or covered person under a group or individual health benefits plan, church plan, or entitled to benefits under Medicare.	Documentation for the appropriate "child" type (as noted above), **and** a copy of the front page of the child's federal tax return* (Form 1040) from last year, and if the child resides outside of the State of New Jersey, documentation of full time student status must be submitted.

You may black out all financial information and all but the last four digits of any Social Security numbers on tax returns. To obtain copies of the documents listed above, contact the office of the town clerk in the city of the birth, marriage, etc., or visit these websites: ***www.vitalrec.com or ***www.studentclearinghouse.org***
Residents of New Jersey can obtain records from the State Bureau of Vital Statistics and Registration website: ***www.nj.gov/health/vital/index.shtml***