HC-1011-1217

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

HIGH DEDUCTIBLE HEALTH PLAN

COBRA APPLICATION

1. EMPLOYEE INFORMATION — Employee Name *(last, first)*

Gender	Birth Date	Social Security Number	Marital Status
	/ /		

Telephone Number	Personal E-mail Address
( )	

Home Address No. and Street Name

City | State | Zip

DIVISION USE ONLY

Effective Dates

H_____ _____ _____

P_____ _____ _____

D_____ _____ _____

V_____ _____ _____

Event Reason

Location # ☐☐☐☐☐☐☐

Term (mos) ☐☐

2. CHANGE OF INFORMATION — TYPE

☐ STATUS CHANGE *(Indicate reason below)*

- Moved Out of Coverage Area *(Date of Move)* _____/_____/_____
- Add Spouse *(attach Marriage Certificate) (Date of Event)* _____/_____/_____
- Add Civil Union/Domestic Partner *(attach Civil Union or Domestic Partnership Certificate) (Date of Event)* _____/_____/_____
- Add Dependent Child Birth (Date of Event) _____/_____/_____ Adoption/Guardianship *(Date of Event)* _____/_____/_____ *(proof required)*

☐ OPEN ENROLLMENT ☐ OTHER _____

3a. HEALTH SAVINGS ACCOUNT (HSA)

☐ I wish to establish a HSA at this time and understand that I will be contacted to establish banking.

By applying for and funding your HSA you represent that you:

- are covered under a High Deductible Health Plan;
- are not covered by any other non-HDHP product;
- are not enrolled in Medicare; and
- cannot be claimed as a dependent on another person's tax return.

To enroll in the Health Savings Account (HSA), complete the attached HSA contribution form to authorize deductions.

☐ I am not enrolling in a HSA at this time and understand that if I choose to at a later date, I must contact my carrier.

3b. HIGH DEDUCTIBLE (HDHP) MEDICAL COVERAGE *(check one box only)*

SHBP – Horizon

☐ NJ DIRECT HD4000

☐ NJ DIRECT HD1500

SEHBP – Horizon

☐ NJ DIRECT HD1500

SHBP – Aetna

☐ Aetna Value HD4000

☐ Aetna Value HD1500

SEHBP – Aetna

☐ Aetna Value HD1500

☐ I elect to waive medical coverage in any medical plan

3c. LEVEL OF COVERAGE

☐ Single (S)

☐ Member & Spouse (M&S)

☐ Member & Civil Union (M&CU)

☐ Member & Domestic Partner (M&DP)

☐ Parent & Child(ren) (P&C)

☐ Family (F)

4. DENTAL PROVIDER INFORMATION

Level of Coverage: ☐ S ☐ M&S/CU ☐ M&DP ☐ P&C ☐ F

Dental Plan *(check one)*: ☐ Dental Expense Plan ☐ Dental Plan Organization

Enter Name of DPO _____ Provider ID# _____

5. VISION (State Only)

☐ S ☐ M&S/CU

☐ M&DP ☐ P&C ☐ F

6. 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**

EMPLOYEE CERTIFICATION – I certify that all the information supplied on this form is true to the best of my knowledge. I hereby make application to extend my group insurance coverage under the terms of the program. I understand that my COBRA coverage will be continuous from the date benefits end. I authorize the Division of Pensions & Benefits to bill me for monthly premium payments and agree to make said payments in a timely fashion or COBRA coverage will terminate without notice. I understand that if I waive my right to coverage at this time, enrollment is not normally permissible at a later date. I also understand that there is no guarantee of continuous participation by medical or dental service providers, either doctors, dentists, or facilities. If my physician, dentist, or medical/dental center terminates participation in my selected plan, I must elect another doctor/dentist or medical/dental center participating in that plan to receive the in-network benefit. I authorize any hospital, physician, dentist, or health or dental care provider to furnish my medical or dental plan or its assignee with such medical or dental information about myself or my covered dependents as the assignee may require. I agree to notify the COBRA Administrator if I or any of my covered dependents become covered under another group health or dental plan or become entitled to Medicare after I elect coverage under COBRA. **Misrepresentation:** Any person that knowingly provides false or misleading information is subject to criminal and civil penalties.

7. Employee Signature:_____ **Date:** _____/_____/_____

DO NOT SEND PAYMENT WITH APPLICATION — YOU WILL BE BILLED

INSTRUCTIONS FOR THE SHBP/SEHBP HIGH DEDUCTIBLE COBRA APPLICATION

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 – CHANGE OF INFORMATION – Check one block only

- Status Change *(Indicate reason)*
  Moved Out of Coverage Area – *(Date of Move)*
  Add Spouse – *(Date of Event) – (attach Marriage Certificate)*
  Add Civil Union/Domestic Partner – *(Date of Event) – (attach Civil Union or Domestic Partnership Certificate)*
  Add Dependent Child/Birth/Adoption/Guardianship *(Date of Event) (proof required)*
- Open Enrollment – Annually in October
- Other *(specify)*

SECTION 3a. – HEALTH SAVINGS ACCOUNT (HSA) – Check one box only – Indicate by checking the appropriate box to establish an HSA. If you are enrolling in the HSA, you will also need to file the attached HSA contribution form. If you do not wish to enroll in a HSA please indicate that in the appropriate box.

SECTION 3b. – HIGH DEDUCTIBLE (HDHP) MEDICAL COVERAGE – Check one box only – Indicate by checking the appropriate box to enroll in or waive coverage in a Health care plan.

SECTION 3c. – LEVEL OF COVERAGE – Check one box only.

- **Single** – coverage for you only
- **Parent/Child(ren)** – coverage for you and any eligible child(ren) under age 26
- **Member/Spouse/Civil Union** – coverage for you and your eligible spouse or your Civil Union Partner
- **Member/Domestic Partner** – coverage for you and your eligible Domestic Partner
- **Family** – coverage for you, your eligible Spouse/Civil Union Partner/Domestic Partner, and child(ren) under age 26

SECTION 4 – DENTAL PLAN INFORMATION – Check the level of coverage for you and/or your eligible dependents. Then choose either the Dental Expense Plan or the Dental Plan Organization (DPO). If you choose the DPO, enter the name of DPO the DPO Provider ID#.

SECTION 5 – VISION COVERAGE (State Only) Check the level of coverage for you and/or your eligible dependents.

SECTION 6 – 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. Your child(ren) may be covered until the end of the calendar year they turn 26. **ANY DEPENDENTS NOT LISTED WILL NOT BE COVERED.**

SECTION 7 – EMPLOYEE SIGNATURE – Read, sign, and date application.

MISREPRESENTATION: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties pursuant to N.J.S.A. 17:33A-6c.

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***

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

COBRA NOTICE

Continuation of Health Benefits Coverage Under COBRA

HIGH DEDUCTIBLE HEALTH PLAN COVERAGE
THIS PAGE IS TO BE COMPLETED BY THE EMPLOYER — PLEASE PRINT

To the Family of —

_____

_____

_____

_____

SS#:_____

Notice Date:_____

Employer Name: _____

Emp ID #:_____

EMPLOYEE TYPE
☐ 10 – month
☐ 12 – month

Dear Member and/or Dependent(s):

Your health care coverage under the State Health Benefits Program (SHBP) or School Employees' Health Benefits Program (SEHBP) terminates as shown below because of a change in employment status or dependent eligibility. The reason for the loss of coverage, the type(s) of coverage lost, and the last day of coverage(s) are shown in the notice below. Under the provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you are entitled to continue your medical benefits with the group program for a limited time.

If you wish to continue coverage under the provisions of COBRA, you must enroll at this time. Otherwise, you will lose coverage and you cannot enroll later.

Please Note: Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of the options at ***www.healthcare.gov***

You may continue the group coverage(s) shown below under COBRA, at your own expense, for the time period shown in the COBRA Continuation Term or until one of the following conditions occur: (1) you voluntarily cancel your coverage; (2) you become covered under MEDICARE or another group plan after you elect COBRA coverage (Note: Exceptions are made if your other group has a pre-existing condition clause that affects you); (3) you fail to pay your premiums in a timely manner; or (4) your employer ends participation in the SHBP/SEHBP.

In considering whether to elect continuation of coverage under COBRA, you should take into account that you cannot enroll at a later date and that a failure to continue your group health coverage may affect your future rights under federal law. Please refer to the *COBRA - The Continuation of Health Benefits* Fact Sheet for more information on your election of COBRA coverage.

If you wish to continue your group coverage under the provisions of COBRA, complete the application and send it to the **Division of Pensions & Benefits, P.O. Box 299, Trenton, NJ 08625-0299**. If you elect to continue coverage, you will be enrolled so you have no break in coverage. After your application is processed (allow up to three weeks), you will be sent a letter of confirmation of enrollment indicating the beginning date(s) of your COBRA coverage(s) and the length of your COBRA eligibility. The Health Benefits Bureau will send you an invoice of premiums that are due for your coverage (this may include retroactive premiums).

You should make a copy of this notice and your completed application for your records prior to mailing the application and any required proof of dependency documentation to the Division of Pensions & Benefits. After mailing, if you do not receive the confirmation of enrollment identified in the preceding paragraph, you should contact the Division of Pensions & Benefits' Office of Client Services at (609) 292-7524 or by e-mail at ***pensions.nj@treas.nj.gov***

COBRA EVENT: (check one)
☐ Termination: Involuntary
☐ Termination: Gross Misconduct
☐ Termination: Voluntary, Other
☐ Reduction in Hours
☐ Leave of Absence
— State/Federal Family Leave
— Other
☐ Death
☐ Divorce or Separation/Dissolution of Civil Union or Domestic Partnership
☐ Dependent Ineligibility Over Age 26
☐ Medicare Entitlement

CURRENT COVERAGE TYPE: *(Circle one)*			
MEDICAL PLAN (*Indicate Plan Name)*:	**DEN-TAL***	**Rx**	**VISION (State Only)**
Single (S)	(S)	(S)	(S)
Member & Spouse(M&S)	(M&S)	(M&S)	(M&S)
Member & Civil Union Partner (M&CU)	(M &CU)	(M&CU)	(M&CU)
Member & Domestic Partner (M&DP)	(M&DP)	(M&DP)	(M&DP)
Parent & Child(ren) (P&C)	(P&C)	(P&C)	(P&C)
Family (F)	(F)	(F)	(F)

***INDICATE DENTAL PLAN**

( ) Dental Expense Plan
( ) Name of Dental Plan Organization:_____

DATE OF COBRA EVENT:_____/_____/_____

CONTINUATION TERM_____ months of COBRA eligibility.

LAST DATE OF COVERAGE: Medical _____/_____/_____ Dental _____/_____/_____ Rx _____/_____/_____ Vision _____/_____/_____

EMPLOYER CONTACT AND TELEPHONE #: _____

_____
Signature of Certifying Officer

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE OR THE LAST DATE OF COVERAGE, WHICHEVER IS LATER, TO ELECT COVERAGE UNDER COBRA. FAILURE TO RESPOND WITHIN THIS TIME PERIOD IS CONSIDERED A DECISION NOT TO CONTINUE COVERAGE.