

**NEW JERSEY STATE HEALTH BENEFITS PROGRAM APPLICATION — ACTIVE EMPLOYEE GROUP** Division of Pension and Benefits, P.O. Box 299, Trenton, NJ 08625-0299 HA-0709-0110

**1. EMPLOYEE INFORMATION**-This section must be filled out completely. Please print or type.

Social Security Number  
 -  -

Last Name Title (Jr., Sr., etc.)

First Name MI

Street Address (Include Apartment #)

City State

ZIP Code + 4 Date of Birth (mm/dd/yy) Gender (M/F)  
 -  / /

Status:  
 -Single  -Married  -Civil Union  -Domestic Partnership  -Divorced  -Widowed

Are you transferring from another SHBP participating employer?  Yes  No

(Area Code) Home Telephone Number If yes, name of employer:  
 -  -

**2. MEDICAL COVERAGE**

**2a. EMPLOYEE SELECTION**  
 I wish to be covered under NJ PLUS.  
 Enter your NJ PLUS Primary Care Physician's ID#

I wish to be covered under an HMO.  
 \_\_\_\_\_ Name of HMO \_\_\_\_\_ HMO#  
 Enter your HMO Primary Care Physician's ID#

I am changing medical plans only:  
 From \_\_\_\_\_ to \_\_\_\_\_

I elect to waive medical coverage in any medical plan (see instructions).

**2b. LEVEL OF COVERAGE**  
 Single  Member and Spouse/Civil Union Partner  
 Member and Domestic Partner (see instructions)  
 Family  Parent and Child(ren)

**3. PRESCRIPTION DRUG COVERAGE** — See note below

**3a. EMPLOYEE SELECTION**  
 I wish to be covered by the Employee Prescription Drug Plan.  
 I elect to waive Employee Prescription Drug Plan coverage.

**3b. LEVEL OF COVERAGE**  
 Single  Member and Spouse/Civil Union Partner  
 Member and Domestic Partner (see instructions)  
 Family  Parent and Child(ren)

**Note:** Prescription Drug coverage is available to all State employees. Local/Educational employers must have elected to provide the SHBP Employee Prescription Drug Plan to employees as a separate prescription drug benefit to be eligible for this coverage. If you are eligible for prescription drug coverage through another employer provided plan, or if your employer does not provide a separate drug plan, do not complete this selection. (If your Local/Educational employer does not provide any separate drug coverage, your SHBP medical plan will include a prescription drug benefit.)

**DIVISION USE ONLY**

Effective Dates: \_\_\_\_\_ Event Reason: \_\_\_\_\_  
 H \_\_\_\_\_   
 P \_\_\_\_\_

**EMPLOYER CERTIFICATION**  
*See instructions on reverse*

Employer Name: \_\_\_\_\_  
 Payroll # (State Biweekly) \_\_\_\_\_ Union Code (Rx) Only \_\_\_\_\_

Location # (State Monthly and Local/Educational)  
   -    
 10/12 month employee (Enter "10" or "12")

**MEMBER ACTION**  
 New Enrollment  Transfer  
 Date Employment Began \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 (mm/dd/yy)  
 Return from Leave of Absence \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 (mm/dd/yy)

\_\_\_\_\_  
 Signature of Certifying Officer

Telephone # \_\_\_\_\_ Date Mailed \_\_\_\_\_

**4. DEPENDENT INFORMATION** - List only eligible dependents (see instructions on reverse).

<input type="checkbox"/> Spouse/Civil Union/Domestic Partner	Last Name	First Name	MI	Date of Birth (mm/dd/yy)	Gender (M/F)	Social Security Number	Dependent's NJ PLUS or HMO Primary Care Physician ID#	Natural (C) Adopted (A) Foster (F) Step (S) Legal Ward (L) See Instructions
<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/>	<input type="text"/>

**5. TYPE OF ACTIVITY**

(complete only if requesting changes to existing coverage)

**5a. ADDITION OF DEPENDENT**

Marriage - Date of Event (mm/dd/yy) \_\_\_\_\_  
 (Copy of Marriage Certificate required)  
 Former Name \_\_\_\_\_

Civil Union/Domestic Partner - Date of Event (mm/dd/yy) \_\_\_\_\_  
 (Copy of Certificate of Civil Union or Domestic Partnership required)

Birth of Child  Adoption/Guardianship - proof required  
 Date of Event (mm/dd/yy) \_\_\_\_\_

**5b. DELETION OF SPOUSE OR PARTNER**

Divorce  Dissolution of Civil Union  Death  
 Termination of Domestic Partnership  
 Date of Event (mm/dd/yy) \_\_\_\_\_

**5c. DELETION OF CHILD**

Deletion of Child - Date of Event (mm/dd/yy) \_\_\_\_\_  
 Child's Name \_\_\_\_\_  
 Child's SSN \_\_\_\_\_  
 Give Reason \_\_\_\_\_

**5d. OTHER CHANGES**

Change in last name only (Attach copy of supporting documentation)  
 (List former name) \_\_\_\_\_

Change in Soc. Sec. # (Attach copy of Social Security card)  
 (List former Soc. Sec. #) \_\_\_\_\_

Change in Birth Date (Attach copy of birth certificate)  
 (List name and correct date) \_\_\_\_\_

Other - give reason (i.e., address change, dependent returns from military service) \_\_\_\_\_

**6. 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 until the next scheduled open enrollment or if other coverage is lost and proof of loss is provided (HIPAA). I also understand that there is no guarantee of continuous participation by medical providers, either doctors or facilities in the NJ PLUS and HMO plans. If either my physician or medical center terminates participation in my selected plan, I must select another doctor or medical center participating in that plan to receive the "in-network" benefit. I authorize any hospital, physician, or health care provider to furnish my medical plan or its assignee with such medical 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.

Employee Signature \_\_\_\_\_ Date Completed \_\_\_\_\_

## INSTRUCTIONS FOR THE NJ STATE HEALTH BENEFITS PROGRAM APPLICATION STATE AND LOCAL/EDUCATIONAL ACTIVE EMPLOYEE GROUP

- **To change your primary care physician (PCP)** with NJ PLUS or your HMO, contact your health plan directly. **DO NOT COMPLETE THIS FORM JUST TO CHANGE YOUR PRIMARY CARE PHYSICIAN.**
- **To enroll** for the first time complete all sections of the application with the exception of section 5.
- **To change health plans only** complete sections: 1, 2a and 2b (if enrolling in an HMO or NJ PLUS be sure to list your primary care physician's identification number), 4 (listing all eligible dependents), and 6.
- **To change coverage level** (adding/deleting dependents) complete sections: 1, 2a and 2b, 3a and 3b (if prescription drug coverage is provided by your employer), 4 (listing all eligible dependents), 5 (listing why you are changing coverage level), and 6.
- **To add a dependent** complete sections: 1, 2a and 2b, 3a and 3b (if prescription drug coverage is provided by your employer), 4 (listing all eligible dependents), 5a, and 6.
- **To terminate/decline coverage** complete sections: 1, 2a and/or 3a (as applicable), and 6. (If you are eligible to waive coverage under the provisions of NJSA 52:14-17.31(a), you must also complete and attach the *Waiver/Reinstatement Declaration* form available from your employer.) If you are declining enrollment for yourself or any or all of your eligible dependents because of other group health insurance coverage, you may in the future be able to enroll yourself and/or your eligible dependents in a SHBP medical plan, provided that you request enrollment within 60 days after other group health coverage ends.

### SECTION 1 - EMPLOYEE INFORMATION

This section must be completed in its entirety each time an application is submitted. The employee enrolling or enrolled in the plan completes this section.

### SECTION 2 - MEDICAL COVERAGE

**2a.** Check only one box indicating the medical plan you wish to be enrolled in. If you do not want medical coverage or wish to cancel coverage, check the box to waive coverage.

**2b.** If you are electing coverage, check the level of coverage desired.

**SPOUSE:** This is a person of the opposite sex to whom you are legally married. A photocopy of the *Marriage Certificate* is required for enrollment.

**CIVIL UNION PARTNER:** This is a person of the same sex with whom you have entered into a civil union. A photocopy of the New Jersey *Civil Union Certificate* or a valid certification from another jurisdiction that recognizes same-sex civil unions is required for enrollment. The cost of a civil union partner's coverage may be subject to federal tax (see your employer or Fact Sheet #75, *Civil Unions*, for details).

**DOMESTIC PARTNER:** This is a same-sex domestic partner, as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act, of any State employee, State retiree, or an eligible employee or retiree of a SHBP participating local public entity if the local governing body adopts a resolution to provide Chapter 246 health benefits. A photocopy of the New Jersey *Certificate of Domestic Partnership* dated prior to February 19, 2007 or a valid certification from another jurisdiction that recognizes same-sex domestic partners is required for enrollment. The cost of same-sex domestic partner coverage may be subject to federal tax (see your employer or Fact Sheet #71, *Benefits Under the Domestic Partnership Act*, for details).

### SECTION 3 - PRESCRIPTION DRUG COVERAGE

**The Employee Prescription Drug Plan is available to State employees and to only Local/Educational employees whose employers have adopted a resolution to provide this coverage.** If the Employee Prescription Drug Plan is provided by your employer:

**3a.** To enroll, check the box to indicate that you wish to be covered. If you do not want prescription drug coverage or wish to cancel coverage, check the box to waive coverage.

**3b.** If you are electing coverage, check the level of coverage desired. (if enrolling a domestic partner, see "Domestic Partner" under 2b above).

**NOTE: Once you decline or cancel Medical or Prescription Drug coverage, enrollment is not permissible until the next open enrollment period or if other coverage is lost and proof of loss is provided (HIPAA).**

### SECTION 4 - DEPENDENT INFORMATION

**Only eligible dependents may be listed.** Completion of this section is essential for proper enrollment. Be sure dependents listed agree with the level of coverage selected in sections 2b, and 3b. List the name, date of birth, gender, and Social Security number of the family members you wish to be covered under the plan. You may list an eligible spouse, civil union partner, or same-sex domestic partner (see definitions in Section 2, above). If you have listed a child who is an adopted child, foster child, stepchild, legal ward, has a different last name than the employee, or if the member has a Parent/Child contract, proof of dependency is required (contact your payroll/personnel representative for an *SHBP Affidavit of Dependency* form). If you have more than 4 eligible dependent children, attach a separate application and complete Sections 1, 4, and 6. For all dependents, include the NJ PLUS or HMO Primary Care Physician identification number. All dependents must have this information listed. Refer to the NJ PLUS or HMO directory or Web site for this information, or call the health plan directly. Plan Web site and phone number can be found on the *Comparison Summary Chart*.

**NOTE: If you are deleting dependents, do not list them in this section. Refer to section 5b and 5c.**

### SECTION 5 - TYPE OF ACTIVITY

**5a.** If you are adding a dependent, check the appropriate box and indicate the event date.

**5b.** If you are deleting a dependent spouse, civil union partner, or domestic partner, check reason and indicate the event date.

**5c.** If you are deleting a dependent child, indicate the event date, list the child's Social Security number, and give reason.

**5d.** For other changes, check the appropriate box, give requested information, and attach a copy of supporting documentation if applicable.

### SECTION 6 - EMPLOYEE CERTIFICATION

You must read the Employee Certification statement, **sign it, and date the application.**

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

### EMPLOYER CERTIFICATION

**Must be completed by your employer** before submitting the application to the SHBP. By signing this application the employer certifies that:

- 1) The employee is eligible;
- 2) The application is legible and completed in its entirety;
- 3) The employee's selected plans and coverage levels are appropriate;
- 4) The Employer Certification section is completed in its entirety; and
- 5) The information presented is true to the best of their knowledge.

## REQUIRED DOCUMENTATION FOR SHBP/SEHBP 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 their eligible dependents are receiving health care coverage under the programs. As a result, the Division of Pensions and Benefits 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 dependents, and over age children continuing coverage) must submit the following documentation in addition to the appropriate health benefits enrollment or change of status application.

DEPENDENTS	ELIGIBILITY DEFINITION	DOCUMENTATION REQUIRED
<b>SPOUSE</b>	A person of the opposite sex to whom you are legally married.	A photocopy of the <i>Marriage Certificate</i> <b>and</b> a photocopy of the top half of the front page of the employee/retiree's most recently filed federal tax return* ( <i>Form 1040</i> ) that includes the spouse.
<b>CIVIL UNION PARTNER</b>	A person of the same sex with whom you have entered into a civil union.	A photocopy of the <i>New Jersey Civil Union Certificate</i> or a valid certification from another jurisdiction that recognizes same-sex civil unions <b>and</b> a photocopy of the top half of the front page of the employee/retiree's most recently filed New Jersey tax return* that includes the partner <b>or</b> a photocopy of a recent (within 90 days of application) bank statement or bill that includes the names of both partners and is received at the same address.
<b>DOMESTIC PARTNER</b>	A person of the same sex with whom you have entered into a domestic partnership. Under Chapter 246, P.L. 2003, 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 photocopy of the <i>New Jersey Certificate of Domestic Partnership</i> dated prior to February 19, 2007 or a valid certification from another State or foreign jurisdiction that recognizes same-sex domestic partners <b>and</b> a photocopy of the top half of the front page of the employee/retiree's most recently filed New Jersey tax return* that includes the partner <b>or</b> a photocopy of a recent (within 90 days of application) bank statement or bill that includes the names of both partners and is received at the same address.
<b>CHILDREN</b>	Your unmarried children under age 23 who: live with you in a regular parent-child relationship; are away at school; or are divorced children living at home provided that they are dependent upon you for support and maintenance.  If you are a single parent, divorced, or legally separated, your children who do not live with you are eligible if you are legally required to support those children. Stepchildren, foster children, legally adopted children, and children in a guardian-ward relationship are also eligible provided they live with you, are under the age of 23, and are substantially dependent upon you for support and maintenance.	<b>Natural Child</b> – A photocopy of the child's birth certificate showing the name of the employee/retiree as a parent. <b>Step Child</b> – A photocopy of the child's birth certificate showing the name of the employee/retiree's spouse or partner as a parent <b>and</b> a photocopy of the marriage/partnership certificate showing the names of the employee/retiree and spouse/partner. <b>Legal Guardian, Adoption, Grandchild(ren), or Foster Child(ren)</b> – Photocopies of Affidavits of Dependency, Final Court Orders with the presiding judge's signature and seal, <b>or</b> Adoption Final Decree with the presiding judge's signature and seal. <b>AND</b> <b>Along with the documentation listed above</b> , a photocopy of the top half of the front page of the employee/retiree's most recently filed federal tax return* ( <i>Form 1040</i> ) that includes the child.
<b>DEPENDENT CHILDREN WITH DISABILITIES</b>	If a covered child is not capable of self-support when he or she reaches age 23 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, and (2) the child continues to be disabled, and (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" dependent type as noted above (including tax forms*) <b>and</b> if Social Security disability has been awarded, or is currently pending, please include this information in the documentation submitted.  <b>Please note</b> 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.
<b>CONTINUED COVERAGE FOR OVER AGE CHILDREN</b>	Certain dependent children may be eligible for continued coverage under the provisions of Chapter 375, P.L. 2005. 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" dependent type as noted above (including tax forms*) <b>and</b> if the over age child is not listed on the employee/retiree's tax return, a copy of the top half of the child's most recently filed federal tax return* ( <i>Form 1040</i> ) is required <b>and</b> if the child resides outside of the State of New Jersey, documentation of full-time student status must be provided.

**\*Note:** For tax forms you may black out all financial information and all but the last 4 digits of any Social Security numbers.

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 Web sites: [www.vitalrec.com](http://www.vitalrec.com) or [www.studentclearinghouse.org](http://www.studentclearinghouse.org)  
Residents of New Jersey can obtain records from the State Bureau of Vital Statistics and Registration Web site: [www.state.nj.us/health/vital/index.shtml](http://www.state.nj.us/health/vital/index.shtml)