NOTICE: This application requires printing on 8 1/2 x 14 inch paper.

PART-TIME EMPLOYEES GROUP — NEW JERSEY STATE HEALTH BENEFITS PROGRAM APPLICATION HA-0679-1203p

Division of Pensions and Benefits, P.O. Box 299, Trenton, NJ 08625-0299

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) ___

Marital Status: ☐ - Single ☐ - Married ☐ - Divorced ☐ - Widowed

(Area Code) Home Telephone Number ___ — ___ — ____

Are you transferring your health benefits from another SHBP participating employer?

No ☐ Yes ☐ If yes, name of employer _____

2. MEDICAL COVERAGE

2a. EMPLOYEE SELECTION

☐ I wish to be covered under NJ PLUS **and** the Employee Prescription Drug Plan.

☐ I wish to be covered under NJ PLUS **only** — and waive Prescription Drug Plan coverage.

Enter your NJ PLUS Primary Care Physician's ID # ____ 0 0 0 0

2b. LEVEL OF NJ PLUS COVERAGE

☐ - Single ☐ - Family ☐ - Member & Spouse ☐ - Parent & Child(ren)

2c. LEVEL OF PRESCRIPTION DRUG COVERAGE

☐ - Single ☐ - Family ☐ - Member & Spouse ☐ - Parent & Child(ren)

3. WAIVER OF COVERAGE

☐ I elect to **waive** medical and prescription drug coverage for myself and for my dependents (see instructions).

4. DEPENDENT INFORMATION — *List all eligible dependents (see reverse).*

	Last Name	First Name	Date of Birth Month Day Year	Gender	Social Security Number	NJ PLUS Primary Care Physician's ID Number	Natural (C) Adopted (A) Step (S) Foster (F) Legal Ward (L)
Spouse							
Children							

5. TYPE OF ACTIVITY (if other than enrollment of a NEW employee)

5a. ADDITION OF DEPENDENT

☐ Marriage - Date (Mo/Day/Yr) _____

Former Name _____

☐ Birth of Child ☐ Adoption/Guardianship — Proof Required

Date of Event (Mo/Day/Yr) _____

5b. DELETION OF DEPENDENT

☐ Separation ☐ Divorce ☐ Death of Spouse or Child

Date (Mo/Day/Yr) _____

☐ Deletion of Child - Date of Event (Mo/Day/Yr) _____

Child's Name _____

Child's SSN _____

Give Reason _____

5c. OTHER CHANGES

☐ Change in last name only

(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 below (*i.e.*, address change, dependent returns from military service)

_____

_____

_____

DIVISION USE ONLY

Effective Dates: ____ ____ ____ ____ ____ ____

Event Reason: ____

EMPLOYER CERTIFICATION

To Be Completed By Employer

Employer Name: _____

Location # ____ 7 0

STATE ONLY: Payroll # ___ Union Code (Rx) Only ___

MEMBER ACTION:

☐ **New Enrollment** — Must be completed

List Date of Pension Enrollment (Mo/Day/Yr)_____/_____/_____

OR

Pension Number _____ — _____

☐ **Transfer** Date _____/_____/_____

Name of Former Employer _____

☐ **Return from Leave of Absence** _____/_____/_____ (Mo/Day/Yr)

10/12 month employee ___

EMPLOYER CERTIFICATION — I certify that this part-time employee is eligible for enrollment under the provisions of Chapter 172, P.L. 2003, and that the information supplied on this form is true to the best of my knowledge.

_____

Signature of Certifying Officer

_____

Telephone # Date Mailed

6. Employee Certification — I certify that all the information supplied on this form is true to the best of my knowledge. I authorize the Division of Pensions and Benefits to bill me for monthly premium payments as required by the provisions of Chapter 172, P.L. 2003. I understand that if I waive my right to coverage at this time, enrollment is not normally 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 service providers, either doctors or facilities in the NJ PLUS plan. If either my physician or medical center terminates participation in NJ PLUS, I must select another doctor or medical center participating in NJ PLUS 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's Signature Date Completed

COMPLETING THE PART-TIME EMPLOYEES GROUP NJ STATE HEALTH BENEFITS PROGRAM APPLICATION

QUICK REFERENCE

- This application is for use by part-time State employees and part-time faculy members at a state college or university, or county or community college who are eligible for State Health Benefits Program coverage under Chapter 172, P.L. 2003. For more information about this law and the eligibility requirements for Part-time employees, see Fact Sheet #66, *SHBP Coverage for State Part-time Employees.*
- **To change your primary care physician** (PCP) with NJ PLUS, contact Horizon Blue Cross Blue Shield directly at: 1-800-414-SHBP. **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 coverage level** (adding/deleting dependents) complete sections: 1, 2a, 2b, and 2c (if applicable), 4, (be sure to list **all** eligible dependents), 5 (listing why you are changing coverage level), and 6.
- To **add a dependent** complete sections: 1, 2a and 2b, and 2c (if applicable), 4 (be sure to list all eligible dependents), 5a, and 6.
- To **terminate/decline coverage** complete sections: 1, and either 2a and 2b to terminate/decline prescription drug coverage only **or** 3 to waive **all** coverage, and 6. Note: 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 your 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 if you want NJ PLUS **and** Prescription Drug Plan coverage or NJ PLUS coverage **only**. Be sure to provide your NJ PLUS Primary Care Physician's ID number. Refer to the NJ PLUS directory for this information or call NJ PLUS at 1-800-414-SHBP.

2b. Check the NJ PLUS coverage level desired.

2c. If you are selecting prescription drug coverage, check the Prescription Drug Plan coverage level desired.

SECTION 3 — WAIVER OF COVERAGE

If you do not want coverage under Chapter 172, check this box. Note: Once you decline or cancel coverage, enrollment is not normally 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 2c. List the name, date of birth, gender, and Social Security number of the family members you wish to be covered under the plan. An eligible spouse is an individual to whom you are legally married. If you have listed a child that is a foster child, stepchild, legal ward, or has a different last name than the employee, contact your payroll/personnel representative for instructions regarding required documentation. If you have more than 4 eligible dependent children, attach a separate application and completed Sections 1, 4, and 6. For all dependents, include the NJ PLUS Primary Care Physician identification number. All dependents must have this information listed. Refer to the NJ PLUS directory for this information or call NJ PLUS at 1-800-414-SHBP.

Note: If you are deleting dependents, do not list them in this section. Refer to section 5b.

SECTION 5 — TYPE OF ACTIVITY

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

5b. If you are deleting a dependent, check reason and indicate the event date.

5c. For other changes, check the appropriate box.

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. This application must be certified by the employer before submitting it to the SHBP.

For New Enrollments: The employer must provide the employee's Date of Pension Enrollment (if employee is a new enrollee, enter expected enrollment date based upon submission of the pension Enrollment Application) or the employee's Pension Membership Number.