HB-1173-0825

State of New Jersey • Department of the Treasury

DIVISION OF PENSIONS & BENEFITS — HEALTH BENEFITS BUREAU

P.O. Box 299, Trenton, NJ 08625-0299

P.L. 1999, c. 48 (CHAPTER 48) — EMPLOYER CERTIFICATION FOR HEALTH BENEFITS FOR SURVIVING SPOUSES

To be completed by the employing agency's Health Benefits Certifying Officer.

Retiree's Name _____ Social Security Number _____

Surviving Spouse's Name _____ Social Security Number _____

Employer Name _____ Health Benefits Employer ID Number_____-___

PART 1 — ELIGIBILITY

☐ Surviving spouse IS NOT eligible for employer paid health benefits under the provisions of Chapter 48; OR

☐ I certify that the surviving spouse is eligible for employer paid health benefits under the provisions of Chapter 48.

Is surviving spouse eligible under the provisions of P.L. 2011, c. 78 (Chapter 78)? ☐ Yes ☐ No (If Yes, skip Part 2)

Note: Surviving spouses required to pay a premium share will have the payments deducted from their monthly pension payment, provided the payment is large enough. Surviving spouses who do not receive a pension or whose pension does not cover the cost of the premium share will be billed directly.

Medicare Part B Reimbursement ☐ Yes ☐ No

PART 2 — HEALTH BENEFITS (For medical and prescription coverage only. Please also complete the *Employer Certification for Dental Benefits for Surviving Spouses* form, if applicable).

Percent _____ % or flat amount $_____ paid monthly by employer for health benefits for surviving spouse; AND

Percent _____ % or flat amount $_____ paid monthly by employer for health benefits for dependent children.

OR

Flat amount $ _____to be paid monthly by employer for all available coverage levels.

PART 3 — LIMITATIONS (if none indicated, benefits apply as long as employer participates in the SHBP)

If employer-paid benefits in retirement are for a specified limited time, employer payment of health benefits will terminate upon:

☐ Surviving spouse attains age _____ ; OR

☐ Time limit of _____ months (please convert years to months); OR

☐ Specified date that health benefits will terminate _____/_____/_____

PART 4 — CERTIFICATION

_____ _____ _____/_____/_____

Print Health Benefits Certifying Officer Name *Signature* *Date*

_____ _____

Phone Number *Email Address*

Please return this form to:

State Health Benefits Program
Health Benefits Bureau
P.O. Box 299
Trenton, NJ 08625-0299

Or Email:

Your Designated NJDPB Health Benefits Group Email Box found on the Resources & Support page in your Benefitsolver Administrator account.