HA-0109-0510p

STATE OF NEW JERSEY
DEPARTMENT OF THE TREASURY
DIVISION OF PENSIONS AND BENEFITS
PO BOX 299
TRENTON, NJ 08625-0299

COVERAGE WAIVER/REINSTATEMENT FOR LOCAL GOVERNMENT/EDUCATIONAL EMPLOYEES

STATE HEALTH BENEFITS PROGRAM
SCHOOL EMPLOYEES' HEALTH BENEFITS PROGRAM

Part 1: To be completed by the employee. Please print.

1. Name _____ SS# _____

Check one box below.

☐ **Waiver of Coverage**

In accordance with Chapter 92, P.L. 2007 and Chapter 2, P.L. 2010, I have agreed to waive coverage (medical and, if applicable, prescription drug coverage) with the State Health Benefits Program (SHBP) or School Employees' Health Benefits Program (SEHBP) to which I am entitled because I am covered under other health coverage. I understand that I am not eligible for the waiver incentive if my other coverage is with the SHBP or SEHBP. (**Note:** You must submit proof of the other health coverage to your employer along with this form.)

In place of health benefit coverage, my employer will pay me the amount shown in Part 2 below. I understand that I may resume SHBP or SEHBP coverage when I am no longer covered by the other health coverage, provided that I notify the Health benefits Bureau within 60 days of the loss of the other coverage and provide proof of loss of that coverage.

☐ **Reinstatement of Coverage**

I previously waived SHBP or SEHBP coverage because I had other health coverage.

As of _____, I am no longer covered by the other health plan, request reinstatement of health benefits
(date)
coverage with the SHBP or SEHBP, and have provided proof of loss of the other coverage. I further understand that coverage is permitted as an employee, retiree, or dependent, however, multiple coverage under the SHBP or SEHBP is prohibited.

Employee's Signature _____ **Date** _____

Part 2: To be completed by the employer. Check one box below.

☐ We will pay the above employee $_____ every _____ in place of providing State Health Benefits Program or School Employees' Health Benefits Program coverage. We understand that this payment may not be more than 25% of the amount saved by the employer because of the waiver **or** $5,000, whichever is less.

☐ We request reinstatement of this employee's State Health Benefits Program or School Employees' Health Benefits Program coverage.

A completed *Health Benefits Program Application* must be attached to either a waiver or a reinstatement. If the application for waiver is received by the Health Benefits Bureau by the 5th of the month, the change will take place on the first of the following month. The reinstatement application must be filed within 60 days of the loss of other health coverage. If this timetable is followed, the coverage will be retroactive to the date of loss. If the 60 day time limit has passed, the employee must wait until the next open enrollment period to reenroll.

Employer Name _____ SHBP/SEHBP Location # _____

Signature of Certifying Officer _____ Date _____

HEALTH BENEFITS PROGRAM APPLICATION — SEHBP EDUCATION ACTIVE EMPLOYEE GROUPS

Division of Pension and Benefits, P.O. Box 299, Trenton, NJ 08625-0299 HA-0890-0913

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

(Area Code) Home Telephone Number

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

☐ No ☐ Yes If yes, list name of employer: _____

2. MEDICAL COVERAGE

2a. EMPLOYEE SELECTION (Choose only one plan)

HORIZON	AETNA
☐ NJ DIRECT15	☐ Aetna Freedom15
☐ NJ DIRECT10	☐ Aetna Freedom10
☐ NJ DIRECT1525	☐ Aetna Freedom1525
☐ NJ DIRECT2030	☐ Aetna Freedom2030
☐ NJ DIRECT2035	☐ Aetna Freedom2035
☐ Horizon HMO	☐ Aetna HMO
☐ Horizon HMO1525	☐ Aetna HMO1525
☐ Horizon HMO2030	☐ Aetna HMO2030
☐ Horizon HMO2035	☐ Aetna HMO2035

For HMO Plans, enter Primary Care Physician's ID#

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

To sign up for a High Deductible Health Plan (HDHP), you must complete a *High Deductible Health Plan Application*. For more information, see your benefits administrator, or go to *www.state.nj.us/treasury/pensions*

2b. LEVEL OF COVERAGE

☐ Single ☐ Member and Spouse/Civil Union Partner
☐ Member and Domestic Partner (see instructions)
☐ Family ☐ Parent and Child(ren)

*Both Medical and (if applicable) Prescription Drug coverage must be waived to avoid paying a contribution.

3. PRESCRIPTION DRUG COVERAGE

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: Education employers must have elected to provide the 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 Education 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: _____

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 and attach required proof of dependency documents (see instructions on reverse).

	Last Name	First Name	MI	Date of Birth (mm/dd/yy)	Gender (M/F)	Social Security Number	Dependent's HMO Primary Care Physician ID#	Natural (C) Adopted (A) Foster (F) Step (S) Legal Ward (L) See Instructions
☐ Spouse/Civil Union/Domestic Partner								
Children								

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 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

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INSTRUCTIONS FOR THE HEALTH BENEFITS APPLICATION
EDUCATION ACTIVE EMPLOYEE GROUPS

- **To change your primary care physician** (PCP) with 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 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 Employee Prescription Drug Plan coverage is provided by your employer), 4 (list all eligible dependents), 5 (list why you are changing coverage level), and 6.
- **To add a dependent** complete sections: 1, 2a and 2b, 3a and 3b (if Employee Prescription Drug Plan coverage is provided by your employer), 4 (list all eligible dependents), 5a, and 6. You must also attach the required proof of dependency documents.
- **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 N.J.S.A. 52:14-17.31(a), you must also complete and attach the *Waiver/Reinstatement Declaration* form available from your employer. Both Medical **and**, if applicable, Prescription Drug coverage must be waived to avoid paying the 1.5% contribution.) 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 or SEHBP 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 the box and indicate 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. Both Medical **and** Prescription Drug must be waived to avoid paying any contribution.

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

SECTION 3 - PRESCRIPTION DRUG COVERAGE

The Employee Prescription Drug Plan is available to only Education Government employees whose employers have adopted a resolution to provide this coverage. If the Employee Prescription Drug Plan is provided:

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. Both Medical **and** Prescription Drug must be waived to avoid paying the 1.5% contribution.

3b. If you are electing coverage, check the level of coverage desired. (if enrolling a domestic partner, see eligibility information in "Domestic Partner" below).

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 cover under the plan. You may list an eligible spouse, civil union partner, or same-sex domestic partner, or your child under age 26 (as defined below). If enrolling in an HMO, include each dependent's HMO Primary Care Physician identification number — all dependents must have this information listed. Refer to the HMO plan's provider directory or Web site for this information, or call the HMO plan directly. Plan Web sites and phone numbers can be found on the *Plan Comparison Summary*.

SPOUSE: This is a person of the opposite sex or same sex to whom you are legally married. A photocopy of the *Marriage Certificate* **and** a photocopy of the employee's most recent Federal tax return* that includes the spouse are 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 **and** a photocopy of the employee's most recent NJ tax return* that includes the partner are required for enrollment. The cost of civil union partner 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 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 **and** a photocopy of the employee's most recent NJ tax return* that includes the partner are 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).

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

CHILDREN: This is your child under age 26. A photocopy of a child's birth certificate showing the name of the employee as a parent is required for enrollment. 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, additional supporting documentation is required. If you have more than three eligible dependent children, attach a separate application and complete Sections 1, 4, and 6.

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, date the application, and attach any required proof for dependents.**

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 Health Benefits Bureau. 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.

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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, eligible children, and 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 children or dependents for coverage (spouses, civil union partners, domestic partners, children, disabled and/or 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
SPOUSE	A person of the opposite sex or same sex to whom you are legally married.	A photocopy of the *Marriage Certificate* **and** a photocopy of the front page of the employee/retiree's most recently filed federal tax return* (*Form 1040*) that includes the spouse.
CIVIL UNION PARTNER	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 **and** a photocopy of the front page of the employee/retiree's most recently filed New Jersey tax return* that includes the partner **or** 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.
DOMESTIC PARTNER	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 *New Jersey Certificate of Domestic Partnership* dated prior to February 19, 2007 or a valid certification from another State of foreign jurisdiction that recognizes same-sex domestic partners **and** a photocopy of the front page of the employee/ retiree's most recently filed New Jersey tax return* that includes the partner **or** 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.
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 photocopy of the child's birth certificate showing the name of the employee/retiree as a parent. **Step Child** – A photocopy of the child's birth certificate showing the name of the employee/retiree's spouse or partner as a parent **and** a photocopy of the marriage/partnership certificate showing the names of the employee/retiree and spouse/partner. **Legal Guardian, Grandchild, or Foster Child** – Photocopies of Final Court Orders with the presiding judge's signature and seal. Documents must attest to the legal guardianship by the covered 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, 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" type (as noted above) **and** a photocopy of the front page of the employee/retiree's most recently filed federal tax return* (*Form 1040*) 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 OVER AGE CHILDREN	Certain children over age 26 may be eligible for continued coverage until age 31 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" type (as noted above) **and** a photocopy of the front page of the child's most recently filed federal tax return* (*Form 1040*), **and** if the child resides outside of the State of New Jersey, documentation of full time student status must be submitted.

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*** or ***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***