

STATE OF NEW JERSEY
DIVISION OF PENSIONS AND BENEFITS
ALTERNATE BENEFIT PROGRAM
ABP LONG TERM DISABILITY INSURANCE
APPLICATION INSTRUCTIONS

THIS PACKET CONTAINS:

Prudential Group Disability Insurance Application

- Employee Statement
- Employer Statement
- Attending Physician Statement
- Employee Tax Notice
- Insurance Authorization
- Electronic Funds Transfer Authorization

ABP Long Term Disability Carrier Election Allocation

SHBP/SEHBP Retired Coverage Enrollment Application

1. An Alternate Benefit Program (ABP) member wishing to apply for a long term disability begins the process by completing the *Disability Insurance Application, Carrier Election and Allocation* form, and *SHBP/SEHBP Retired Coverage Enrollment Application* — accurately providing all requested information and submitting the complete packet to his or her Employer.
2. The employer then provides the employee's salary information for the final 12 months prior to the month in which the disabling event occurred, and sends the completed applications and forms to:

The Division of Pensions and Benefits
Alternate Benefit Program
PO Box 295
Trenton, NJ 08625-0295

3. Upon receipt, the Division of Pensions and Benefits informs the New Jersey SHBP/SEHBP that an ABP long term disability is pending.
4. The Division of Pensions and Benefits then forwards the employee's application to Prudential for initial processing.
5. ABP long term disability processing times vary. If any required information is missing from the application, Prudential will contact the employee or the employer to obtain the necessary information.
6. When all required information has been obtained, Prudential makes a determination as to whether or not the disability is approved and notifies the employee directly. The employer and the Division of Pensions and Benefits are also notified of the determination.

For additional information or if you have questions, contact Prudential at 1-800-842-1718 or write to the Alternate Benefit Program at the address listed above.

The Prudential Insurance Company of America
Disability Management Services
P.O. Box 13480, Philadelphia, PA 19176
Tel: 800-842-1718 Fax: 877-889-4885
<http://www.prudential.com/inst/gldi>

Disability Claim Instructions

Instructions to File a Claim for Disability Benefits

1. Notify your employer of your absence, that you will be filing a claim and request they provide Prudential with their Employer's Statement
2. Complete all Sections of the Employee's Statement
3. Ask your Doctor to complete the Attending Physician's Statement
4. Have these statements submitted according to the directions you received from your Benefits Office
5. If you wish to have voluntary Federal Income Tax withholding from disability benefit payments, read and complete the Tax Notice.

In order for a claim for benefits to be considered filed, Prudential requires an employee's statement, employer's statement, and attending physician's statement to be submitted.

Your Claim Will Be Considered Filed When:

- If you have STD coverage with Prudential, your claim for STD benefits will be considered filed the later of (1) when we receive the employee's statement, the employer's statement and the attending physician's statement, and (2) the start of your STD Elimination Period.
- If you have LTD coverage with Prudential, your claim for LTD benefits will be considered filed the later of (1) when we receive the employee's statement, the employer's statement, and the attending physician's statement, and (2) the date that is 45 days before the end of your LTD Elimination Period.
- If you have both STD and LTD coverages with Prudential and you have filed a claim for STD, there is no need to re-submit the statements noted above for the LTD portion of your claim. However, your claim for LTD benefits will be considered filed in this case the later of (1) when we receive the statements indicated above; and (2) the date that is 45 days before the end of your LTD Elimination period, provided you are receiving STD benefits on that date. If you are approved for STD benefits at a later date, your LTD claim will be considered filed on the date of the STD approval.



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For residents of all states except California, Florida, New Jersey, New York, Pennsylvania, Utah, Vermont, Virginia and Washington: WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

CALIFORNIA RESIDENTS— For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

FLORIDA RESIDENTS— Any person knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree.

NEW JERSEY RESIDENTS— Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW YORK RESIDENTS— Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

PENNSYLVANIA and UTAH RESIDENTS— Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

VERMONT RESIDENTS— Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

VIRGINIA RESIDENTS— Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing a statement of claim for payment of a loss or benefit may have violated state law, is guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

WASHINGTON RESIDENTS— Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company commits a crime. Penalties include imprisonment, fines, and denial of insurance benefits.



1 Employer Information

Employer Name: **S t a t e o f N e w J e r s e y** Control Number: **0 0 1 4 8 0 0**

Location / Division: _____ Branch Number: _____

2 Employee Information

First Name: _____ MI: _____ Social Security Number: _____

Last Name: _____ Suffix: _____

Mailing Address - Line 1: _____

Mailing Address - Line 2: _____ Birth date (MM/DD/Year): _____

City: _____ State: _____ Zip Code: _____ Gender: Male Female Marital Status: Unmarried Married Divorced Widowed

Primary Phone Number: _____ Work Phone Number: _____

Email Address: _____

Date Last Worked (MM/DD/Year): _____ Date First Absent: _____ Date First Treated for this Condition: _____

Date Expected to Return to Work: _____ Spouses Date of Birth: _____ Is Spouse Employed? Yes No

EDUCATION: Highest Grade Completed: _____ Number of Children Under 18: _____ Age of Youngest Child: _____

3 Job Information

Occupation: _____

What Job Category best describes your required job duties? (Please check appropriate box)

Sedentary **Light** **Medium** **Heavy** **Very Heavy** **Other**

Negligible Weight Mostly Sitting | Up to 10 lbs. frequently and/or Frequent Walk/Stand and/or Constant Push/Pull | 10 to 25 lbs. freq. Up to 50 lbs. occ. | 25 to 50 lbs. freq. 50 to 100 lbs. occ. | More than 50 lbs. freq. 100 lbs. occasionally | (Please describe below)

4 Primary Care Physician

Physician Name: _____ Primary Phone Number: _____

Street Address: _____ Fax Number: _____

City: _____ State: _____ Zip Code: _____

For Internal Use Only

Claim Number: _____



Employee Last Name Social Security Number - -

5

Medical Information

All Other Physicians You Have Consulted for this Condition

Physician Name	Specialty	Phone Number

What medical condition is preventing you from working? _____

How does this condition interfere with your ability to perform your job? _____

Have you been hospitalized for this condition? Yes No In-Patient Out-Patient

If hospitalized, give dates: From: / / To: / /

If you are pregnant: Estimated Delivery Date / / Actual Delivery Date / /

Name of Your Health Insurance Company Telephone Number - -

6

Other Income & Workers' Comp. Information

What other income are you entitled to receive as a result of your disability? (Examples: Social Security Disability or Retirement Benefits, Workers' Compensation, State Disability, Pension Disability or Retirement, No-Fault Auto Insurance, Salary Continuance, Group Life or Disability Plan, Health or Welfare Plan, Individual Disability Benefits.) Please send copies of any letters or notices approving or denying benefits.

Source	Applied For Yes No	Amount	Frequency	Date Benefit Begins	Date Benefit Ends
Salary Continuance	<input type="radio"/> <input type="radio"/>				
State Disability Benefits	<input type="radio"/> <input type="radio"/>				
Workers' Compensation	<input type="radio"/> <input type="radio"/>				
Other:	<input type="radio"/> <input type="radio"/>				
Other:	<input type="radio"/> <input type="radio"/>				

Is this condition work related? Yes No If Yes, do you intend to file a Workers' Compensation claim? Yes No

7

Fraud Notice

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. This includes Employer and Attending Physician portions of the claim form. (Please see state specific fraud warnings attached.)

X _____ / / Employee Signature Date Signed



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<http://www.prudential.com/inst/gldi>

Employer Statement

1 Employer Information

Employer's Name: Control Number (required):

Street: Suite: STD Branch (required):

City: State: ZIP Code: LTD Branch (required):

Employer's Telephone Number: Extension: Email Address:

2 Employee Information

First Name: MI: Last Name:

Address 1: Social Security Number:

Address 2: Telephone Number:

City: State: Zip: Gender: Male Female

Please check the type of claim you are filing. Check all that apply:

<input type="checkbox"/> STD Core	<input type="checkbox"/> STD Supplemental _____	Employment Status	Coverage Effective Date (date the employee became covered under the policy).		
<input type="checkbox"/> LTD Core	<input type="checkbox"/> LTD Supplemental _____			<input type="checkbox"/> Salaried Employee	STD: <input type="text"/>
<input type="checkbox"/> TDB (NJ)	<input type="checkbox"/> DBL (NY) <input type="checkbox"/> VDI (CA)			<input type="checkbox"/> Hourly Employee	LTD: <input type="text"/>
		<input type="checkbox"/> Other _____			

Date Hired (MM DD YYYY): Coverage Termination Date (MM DD YYYY): Last Date Employer Paid Compensation (MM DD YYYY):

Date First Absent (MM DD YYYY): Date Last Worked (MM DD YYYY): Date Work Was Resumed (MM DD YYYY):

Normal Earnings Prior to this Absence (exclude bonus, overtime, etc.)

\$, . PER

Hour Week Bi-Weekly (every two weeks)

Month Year Other _____

If employee does not work Monday thru Friday, check days worked:

Varies Wednesday Saturday

Monday Thursday Sunday

Tuesday Friday

Is the employee subject to FICA Withholding?

Yes No

If "No" indicate reason

How was the **STD** premium paid for the plan year in which the disability occurred? _____% paid by employer

Was the premium amount paid by the employer included in the employee's W-2? Yes No

Has either percentage changed within the last 3 years? Yes No

How was the **LTD** premium paid for the plan year in which the disability occurred? _____% paid by employer

Was the premium amount paid by the employer included in the employee's W-2? Yes No

Has either percentage changed within the last 3 years? Yes No



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Attending Physician Statement

1 Employee Information

Employer's Name Control Number (required)

Employee First Name MI Last Name

Social Security Number Date of Birth (MM DD YYYY) Gender Male Female

I hereby authorize the release of information requested on this form by the below named physician for the purpose of claim processing.

Employee Signature _____ Date (MM DD YYYY)

The Employee is responsible for the completion of this form without expense to Prudential.

2 To Be Completed By Attending Physician

Clinical Diagnosis **ICD-9 Code is Required** Primary: Pregnancy EDC (MM DD YYYY) Actual Delivery Date (MM DD YYYY)

Secondary:

Secondary:

Date of Surgical Procedure (MM DD YYYY)

Relevant tests and surgical procedure (s) performed (please be specific):

Current Medications, Treatment and Prognosis:

First Visit (MM DD YYYY) Last Visit (MM DD YYYY) Next Visit (MM DD YYYY)

Was Claimant hospital confined? Yes No

If yes, please provide name and address of hospital

From (MM DD YYYY) To (MM DD YYYY)

Check all that apply to this disability:

Work Related Yes No Accident Yes No Sickness Yes No Maternity Yes No Motor Vehicle Accident Yes No If MVA, what State did it occur?

Other Treating Physicians or Consultants

First Name Last Name Specialty Telephone Number



2
Attending Physician Information (Cont'd.)

Other Treating Physicians or Consultants

First Name Last Name
 Specialty Telephone Number

First Name Last Name
 Specialty Telephone Number

Do you feel the claimant is competent to endorse checks and direct the use of proceeds? Yes No
 Date when significant loss of function occurred: (MM DD YYYY) Return to Work Target Date (MM DD YYYY) Full Time
 Part Time
 With Limitations (functions lost)

Please describe Return to Work Plan and provide any corresponding Limitations:

Please describe any Medical Obstacles to Return to Work:

Nature of Medical Impairment (i.e., loss of function):

Are there any Non-Medical Factors which have a significant impact on Functional Abilities (i.e., interpersonal, financial family)?

3
Physician Information

First Name MI Last Name
 Primary Telephone Number Fax Number
 Office Address Suite
 City State ZIP Code
 Specialty

4
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Physician Signature _____ Date (MM DD YYYY)



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Group Disability Insurance Employee Tax Notice

1 Employee Information

First Name	MI	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>
Social Security Number	Employee Phone Number	
<input type="text"/>	<input type="text"/>	
Email Address		
<input type="text"/>		
Employer's Name	Control Number	
<input type="text" value="State of New Jersey"/>	<input type="text" value="0014800"/>	

***Notice to all parties completing this form: It is fraudulent to fill out this form with information you know to be false or to omit important facts. Criminal and/or civil penalties can result from such acts.**

2 Federal and State Withholding

Benefits provided under your Group Disability Income Plan may be subject to federal, state and local taxation. Contact your employee benefits representative or disability plan trustee for details on your rights and obligations under the various tax codes.

If you wish to have Federal Income Tax (FIT) withheld from any payments you may receive, indicate the amount to be withheld (\$20 weekly minimum for STD/\$88 monthly minimum for LTD) below and sign the authorization. Withholding requests may also be submitted on IRS Form W-4S. Withholding requests must be stated in whole dollar amounts. FIT will not be withheld if the disability benefit is not taxable.

I request voluntary Federal Income Tax withholding from each payment, as authorized under section 3402(c) of the Internal Revenue Code, in the amount(s) of:

For STD .00 weekly (\$20.00 minimum)

For LTD .00 monthly (\$88.00 minimum)

3 Employee Signature

X _____
 Employee Signature

Date (MM DD YYYY)



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Group Disability Insurance Electronic Funds Transfer Authorization

1 Enrollment

To enroll in Prudential's Electronic Funds Transfer (EFT) payment service, please provide the following information. If you elect to have Prudential deposit the funds in your savings account, you must first check with your bank to obtain the correct bank transit routing number and account number for electronic deposit. Please note that a deposit slip does not contain acceptable banking information. If you have any questions, please call us toll free at 800-842-1718.

***Please note that not all policies are designed to participate in the Electronic Funds Transfer option. Contact your employee benefits representative or disability plan trustee for details.**

2 Claimant Information

Employer's Name

S t a t e o f N e w J e r s e y

Claimant's First Name

MI

Last Name

[First Name Boxes] [MI Box] [Last Name Boxes]

Social Security Number

Primary Phone Number

[SSN Boxes] [Phone Number Boxes]

3 Banking Information

Bank Name

[Bank Name Boxes]

Branch Phone Number

Type of Account (SELECT ONE)

[Branch Phone Number Boxes]

Savings

Checking

Bank Transit Routing Number

Bank Account Number

[Routing Number Boxes]

[Account Number Boxes]

(NINE DIGIT BANK TRANSIT ROUTING NUMBER)

(BANK ACCOUNT NUMBER)

4 Payment Plan Agreement

I authorize the Prudential Insurance Company of America to make electronic fund deposits of my disability benefit payment to my account. I understand that any deposit made to an inactive account will be returned to Prudential and reissued as a manual check. In addition, if any overpayment of such disability benefits is credited to my account in error, I authorize Prudential to withdraw any payments necessary in order to assure the accuracy of my claim payments.

I can cancel this authorization at any time by giving Prudential written notice. Any notice hereunder will not be deemed effective until Prudential has received my written notice.

Account Owner

First Name

MI

Last Name

[First Name Boxes] [MI Box] [Last Name Boxes]

Street

Suite

[Street Boxes]

[Suite Boxes]

City

State

ZIP Code

[City Boxes]

[State Boxes]

[ZIP Code Boxes]

Date Signed (MM DD YYYY)

X

Signature

[Date Signed Boxes]



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5 **Instructions for completing Section 3, "Banking Information"**

This will help you identify the necessary bank information to initiate electronic withdraws. The nine-digit transit routing number is how we recognize the bank you do business with.

Record all banking information on page 1 of the form in Section 3, "Banking Information". Please call your bank to confirm that the information you are supplying is correct.

<p>Customer XYZ XYZ Street City, State, ZIP</p>	<p>Check No. 1246</p>	
<p>PAY TO THE ORDER OF _____</p>	<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="text-align: center; width: 40px;">\$</td> </tr> </table> <p>Dollars</p>	\$
\$		
<p>Bank XYZ UXYZ Street City, State, ZIP</p>		
<p>A27202754 006666D6666C 1246</p>		

↑ This is the bank transit routing number. It is always 9 digits and appears between the: symbols. Record this number in the boxes provided in Section 3, "nine-digit bank transit routing number."

↑ This is your bank account number. It varies in number of digits and may include dashes or spaces. The < symbol indicates the end of the account number. Record the account number in the boxes provided in Section 3, "Bank Account Number" and include any dashes and spaces that are within the account number. If there are any digits to the right of the < symbol (which do not represent the check sequence number), record them in the boxes provided.

↑ This is the check sequence number. It may be on either end of your check. Please do not include this on the authorization form.

*This page is **Instructions Only**: It is not necessary to return this page with your EFT Authorization.*



ALTERNATE BENEFIT PROGRAM

INFORMATION FOR NEW APPLICANTS

A *Carrier Election and Allocation* form must be completed to identify the investment carrier(s) with which you want your contributions invested.

- **If you are eligible for immediate vesting**, the employer contributions become your property immediately upon investment in your account. **You may elect any number of investment carriers and designate the percentage (in whole numbers) of the total contributions they each should receive.**
- **If you are not eligible for immediate vesting**, the employer contributions do not become your property until the beginning of the 13th month of your employment. **You may elect only one investment carrier.**

If you do not file a *Carrier Election and Allocation* form, the ABP Administrator will enroll you with the investment carrier selected as the default carrier for the current plan.

You must file an application directly with the investment carrier(s) you have elected or with the default investment carrier if you fail to complete this form. If you fail to do so, you may lose possible revenue from your contributions. Additionally, the carrier(s) you elected will return your contributions to your employer and the ABP administrator will enroll you with the default investment carrier.

INFORMATION FOR VESTED ABP MEMBERS

ABP members may change their investment carrier election and/or allocation once each quarter of the calendar year.

RETIRED COVERAGE ENROLLMENT APPLICATION
State Health Benefits Program - School Employees' Health Benefits Program
New Jersey Division of Pensions and Benefits
P.O. Box 299 • Trenton, NJ 08625-0299

1. APPLICANT INFORMATION

Social Security Number - -

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

First Name Middle Name

Street Address Apartment #

PO Box City State

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

Status (check one) Single Married Civil Union (see instructions)
 Divorced Widowed Domestic Partnership (see instructions)

Were you a part time employee when you retired?
 Yes No

Former Employer

Area Code - Home Telephone Number - Date of Retirement (mm/dd/yy)

	YES	NO
Do YOU have Medicare Part A? (Hospital Insurance)	<input type="checkbox"/>	<input type="checkbox"/>
Do YOU have Medicare Part B? (Medical Insurance)	<input type="checkbox"/>	<input type="checkbox"/>
Does YOUR SPOUSE/PARTNER have Medicare Part A?	<input type="checkbox"/>	<input type="checkbox"/>
Does YOUR SPOUSE/PARTNER have Medicare Part B?	<input type="checkbox"/>	<input type="checkbox"/>

Anyone eligible for Medicare (age 65 or older or in receipt of Social Security Disability benefits for at least 24 months) must be enrolled under both Medicare Part A (Hospital) and Part B (Medical) in order to continue coverage under this program. If enrolled, a photocopy of the Medicare card must be submitted with this application.

If your child has Medicare, list child's name and Social Security Number and attach a copy of the Medicare card.

2. TYPE OF ACTIVITY — Submit this application if you are a **new enrollee** for SHBP or SEHBP Retired Group coverage. Check one box in Section 2A; then complete Sections 3 and 4 to select Medical/Dental Coverage. If you are already enrolled and wish to change coverage, add or delete dependents, or cancel coverage, please submit the *Retired Change of Status Application*.

2A. ENROLLMENT ACTION REQUESTED

New Retiree
 Survivor Enrollment: Decedent's SS#

3A. MEDICAL COVERAGE (Check one box only).

I wish to be covered under **NJ DIRECT15**

I wish to be covered under **NJ DIRECT10** (Certain State retirees may be ineligible for NJ DIRECT10. See the *NJ DIRECT Member Handbook* for eligibility information.)

I wish to be covered under **Aetna HMO.**
 (Enter Aetna HMO Primary Care Physician's ID#)

I wish to be covered under **CIGNA HealthCare HMO.**
 (Enter CIGNA HealthCare Primary Care Physician's ID#)

I **do not wish to be covered** under any of the medical plans (See instructions)

I wish to **waive coverage** under the medical plans for the following reason:
 (See instructions)

I have coverage with another employer I have coverage with spouse/partner's employer
 List Employer

Other (Give Reason)

3B. LEVEL OF COVERAGE (Check one box)

Single Member & Spouse/Civil Union Partner (See Instructions)
 Family Parent/Child(ren) Member & Domestic Partner (See Instructions)

4A. DENTAL COVERAGE (Check one box only)

I wish to be covered by the **Retiree Dental Expense Plan**

I **do not wish to be covered** under the dental plan (See instructions)

I wish to **waive coverage** under the dental plan for the following reason: (See instructions)

I have coverage with another employer I have coverage with spouse/partner's employer
 List Employer

4B. LEVEL OF COVERAGE (Check one box)

Single Member & Spouse/Civil Union Partner (See Instructions)
 Family Parent/Child(ren) Member & Domestic Partner (See Instructions)

4C. PREVIOUS DENTAL COVERAGE

Were you enrolled in a group dental plan for at least 12 months prior to retirement?
 Yes No

If **yes**, please provide:
 Dental Plan Name
 Telephone Number
 Your Dental Plan ID Number

5. DEPENDENT INFORMATION — List eligible dependents to include for coverage and attach required proof of dependency documents (see instructions on reverse). Attach another sheet of paper for three or more dependents.

<input type="checkbox"/> Spouse/Partner	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
<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="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="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"/>

FOR DIVISION USE ONLY

Event Reason Effective Date

Waiver Code Location No.

Waiver Codes: 3 - (voluntary) 4 - (non-response) 5 - (spouse) 6 - (employer)

6. I certify that all the information supplied on this form is true to the best of my knowledge. I authorize a pension deduction from my pension check, including initial check, last check benefit, withdrawal check, or return of contributions check as required by the State Health Benefits Commission or School Employees' Health Benefits Commission. I also understand that there is no guarantee of continuous participation by medical service providers, either doctors or facilities in the NJ DIRECT or HMO plans. I authorize any hospital, physician, dentist, or health or dental care provider to furnish my medical/dental plan or its assignee with such medical/dental information about myself, or my covered dependents on this application, as the assignee may require. I further authorize my current dental plan, if applicable, to release information deemed necessary for enrollment in this plan. **Anyone eligible for Medicare (age 65 or older or in receipt of Social Security Disability benefits) must be enrolled under both Hospital Insurance (Part A) and Medical Insurance (Part B) in order to continue coverage under this program. PROOF OF ENROLLMENT IS REQUIRED.** If I or a covered dependent enroll in Medicare at a later date, I understand that the Health Benefits Bureau must be notified immediately.

Applicant's Signature Date: Additional Sheet Attached Medicare Proof Enclosed

COMPLETING THE RETIRED COVERAGE ENROLLMENT APPLICATION

Be sure to review Fact Sheet #11, *Enrolling in Health Benefits Coverage When You Retire*, to verify that you are eligible for enrollment into the **State Health Benefits Program (SHBP)** or **School Employees' Health Benefits Program (SEHBP)**.

SECTION 1 — APPLICANT INFORMATION

This section pertains to the person enrolling in the retired group. Complete all requested information, filling in one letter or number per block. Provide month, day, and year for Date of Birth and Date of Retirement (for example: April 12, 1933 = 04 12 33). Please indicate if you were a part-time employee.

SECTION 2 — TYPE OF ACTIVITY

Check one box in section 2A. If you have applied for retirement or are a new retiree, check the first box "New Retiree".

If you are enrolling as a Surviving Spouse/Partner or Surviving Dependent, check "Survivor Enrollment."

For changes to existing retired group health benefits coverage **DO NOT USE THIS FORM**. To change plans, add or delete dependents, cancel coverage, and make other changes, SHBP or SEHBP members should complete and submit the *Retired Change of Status Application*.

SECTION 3 — MEDICAL PLAN SELECTION

Check only one box indicating either: **1.)** The medical plan into which you want to enroll; or **2.)** That you do not want medical plan coverage (See "Declining or Waiving Coverage" below); or **3.)** That you want to waive medical plan coverage. (See "Declining or Waiving Coverage" below)

When choosing a HMO plan you must list the identification number (ID #) of your Primary Care Physician.

DECLINING OR WAIVING COVERAGE — If you are declining coverage and do not want SHBP or SEHBP coverage, check the box indicating that you do not wish to be covered under any of the medical/dental plans.

If you are requesting to waive enrollment for yourself and any of your eligible dependents because of other group health or dental insurance coverage from a public or private employer, check the box indicating that you wish to waive coverage, indicate if the coverage is through your employment or that of your spouse/partner, and the name of the employer. If coverage is waived you may in the future be able to enroll yourself and your eligible dependents in a SHBP or SEHBP medical or dental plan, provided that you request enrollment within 60 days after your other employer group health or dental coverage ends — proof of loss of coverage is required. See Fact Sheet #11, *Enrolling in Health Benefits Coverage When You Retire*, for more information. Police and Firemen's Retirement System (PFRS) members enrolling under Chapter 330, P.L. 1997 should refer to Fact Sheet #47, *Retired Health Benefits Coverage Under Chapter 330*, for more information.

LEVEL OF COVERAGE — Select a level of coverage based upon who you will be covering. When you first enroll at the time of retirement, you may add eligible dependents. Your eligible dependents are your spouse or civil union partner, or an eligible same-sex domestic partner, and your children under age 26 (see definitions below).

Indicate whether you and/or your spouse/partner and/or child are enrolled in Medicare Parts A and B. Be sure to list the effective dates of the Medicare enrollment. Proof of full Medicare enrollment in Parts A and B is required by the Health Benefits Bureau. Please submit a photocopy of the Medicare card or a letter from Social Security confirming the effective dates of full Medicare enrollment. Members receiving a Social Security Disability who become Medicare eligible, must be enrolled in the full Medicare program — Part A and Part B — in order to have coverage in the SHBP or SEHBP. If submitting proof of Medicare enrollment, check the box at the bottom right of the application.

SECTION 4 — DENTAL EXPENSE PLAN SELECTION

If eligible, check only one box indicating either: **1.)** that you want to enroll in the Retiree Dental Expense Plan; or **2.)** That you do not want dental coverage (See "Declining or Waiving Coverage" above); or **3.)** That you want to waive dental coverage. (See "Declining or Waiving Coverage" above)

Select a level of coverage based upon who you will be covering. See "Level of Coverage" above for details.

SECTION 5 — SPOUSE/PARTNER AND CHILDREN

This section is used for members selecting Member & Spouse/Partner, Family, or Parent & Child(ren) coverage. Please list your spouse/partner's name, gender, date of birth, Social Security number, and if enrolling in an HMO plan the spouse/partner's Primary Care Physician Identification Number. Please also list the name, gender, date of birth, Social Security number, and if enrolling in an HMO plan the Primary Care Physician Identification Number for any children you are enrolling. If you are listing more than two children, please provide the required information for your other children on an additional sheet of paper, attach the sheet to the application, and check the box at the bottom right of the application.

SPOUSE: This is a person of the opposite sex to whom you are legally married. A photocopy of the *Marriage Certificate* **and** a photocopy of the covered retiree'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 covered retiree'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 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 or SEHBP 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 covered retiree'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 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 retiree 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. A child is only eligible if he or she is **not** eligible to enroll in other employer-based coverage (aside from coverage through the parent).

Note: Dependents may be added later, using the *Retired Change of Status Application*, either within 60 days of the date of event - i.e., marriage, civil union, birth of a child - with an effective date of the date of the event; or added timely with a 60-day waiting period.

SECTION 6 — CERTIFICATION AND SIGNATURE

The member must read the certification and sign and date the application. If Medicare proof or additional sheets are submitted with the application, check the box indicating such.

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

Return this application and all supporting documentation to:

NJ DIVISION OF PENSIONS AND BENEFITS
HEALTH BENEFITS BUREAU
P.O. BOX 299
TRENTON, NJ 08625-0299

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 to whom you are legally married.	A photocopy of the <i>Marriage Certificate</i> and a photocopy of the front page of the employee/retiree's most recently filed federal tax return* (<i>Form 1040</i>) 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 <i>New Jersey Civil Union Certificate</i> 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 <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 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	<p>A subscriber's child until age 26, <i>regardless</i> of the child's marital, student, or financial dependency status – even if the young adult no longer lives with his or her parents.</p> <p>This includes a stepchild, foster child, legally adopted child, or any child in a guardian-ward relationship upon submitting required supporting documentation.</p> <p>Coverage until age 26 is only available if an adult child is <u>not</u> eligible to enroll in other employer-based coverage (aside from coverage through the parent).</p>	<p>Natural or Adopted Child – A photocopy of the child's birth certificate showing the name of the employee/retiree as a parent.</p> <p>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.</p> <p>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.</p>
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.	<p>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* (<i>Form 1040</i>) that includes the child.</p> <p>If Social Security disability has been awarded, or is currently pending, please include this information with the documentation that is submitted.</p> <p>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.</p>
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* (<i>Form 1040</i>), 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