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

STATE EMPLOYEE COVERAGE WAIVER/REINSTATEMENT
STATE HEALTH BENEFITS PROGRAM

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

1. Name _____ SS# _____

Check one box below.

☐ **Waiver of Coverage**

I agree to voluntarily waive State Health Benefits Program (SHBP) coverage to which I am entitled because I am covered under other health coverage. I understand that while coverage is waived, I will not be required to make payroll contributions required for medical and/or prescription drug coverage.

I understand that I may resume State Health Benefits Program coverage if I lose coverage under the other health coverage, provided that I notify the SHBP within 60 days of the loss of the other coverage and provide proof of loss of that coverage.

☐ **Reinstatement of Coverage**

I previously waived State Health Benefits Program coverage because I had other health coverage.

As of _____, I am no longer covered by the other health plan, request reinstatement of the State
(date)
Health Benefits Program coverage, 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 State Health Benefits Program is prohibited.

Employee's Signature _____ **Date** _____

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

☐ We understand that this employee is requesting to voluntarily waive State Health Benefits Program coverage.

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

A completed *State Health Benefits Program Application* must be attached to either a waiver or a reinstatement. 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 Location # _____

Signature of Certifying Officer _____ Date _____