CANCEL/DECLINE/WAIVE RETIRED COVERAGE FORM

HR-0976-0916

State Health Benefits Program – School Employees' Health Benefits Program

New Jersey Division of Pensions and Benefits Program
PO Box 299 • Trenton, NJ 08625-0299

APPLICANT INFORMATION

Social Security Number ___-___-____

Date of Retirement *(mm/dd/yy)* ____/____/____

Date of Birth *(mm/dd/yy)* ____/____/____

Gender *(M/F)* ____

Last Name _____

Title *(Jr., Sr., etc.)* ____

First Name _____

MI ____

PO Box or Street Address *(Include Apartment #)* _____

City _____

State ____

Zip Code + 4 _____-____

Area Code ___ Home Telephone Number ___-____

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

Former Employer:_____

CANCEL / DECLINE ALL COVERAGE - FOR THOSE THAT DO NOT WANT COVERAGE, PERMANENTLY

☐ I am newly eligible to enroll, but I wish to decline all coverage. I understand that I will not be permitted to enroll with the SHBP/SEHBP at a later date.

☐ I am currently enrolled and wish to cancel all coverage. I understand that I will not be permitted to enroll with the SHBP/SEHBP at a later date.

☐ I wish to decline/cancel my SHBP/SEHBP DENTAL coverage only. I understand that I will not be permitted to enroll in the SHBP/SEHBP dental plans at a later date. My enrollment in medical coverage will not be affected.

WAIVE COVERAGE – FOR THOSE THAT HAVE OTHER COVERAGE AND MAY WISH TO ENROLL LATER

NOTE: Waiver allowed only for other employer or spouse's employer coverage. Re-enrollment is not permitted if other coverage is private insurance (i.e.; AARP, Humana, etc.).

Retirees are permitted to enroll in medical but waive dental coverage, or to enroll in dental but waive medical coverage, or to waive both.

☐ I am newly eligible to enroll, but I am enrolled in another group plan and wish to waive coverage. In order to enroll with the SHBP/SEHBP at a later date, I understand that I must submit a Retired Change of Status Application, along with proof of coverage loss, within 60 days of losing the other coverage.
Check applicable box: ☐ Medical Only ☐ Dental Only ☐ Both * Name of Employer _____

☐ I am currently enrolled in the SHBP/SEHBP, but wish to waive coverage while enrolled in another group plan. In order to re-enroll later, I understand that I must submit a Retired Change of Status Application, along with proof of coverage loss, within 60 days of losing the other coverage.
Check applicable box: ☐ Medical Only ☐ Dental Only ☐ Both ** Name of Employer _____

***If you are newly eligible to enroll and wish to waive only one type of coverage, you must also submit a Retired Coverage Enrollment Application to enroll in the coverage of your choice.

****If you are currently enrolled in the SHBP/SEHBP and wish to waive only one type of coverage, this is the only form you need to submit at this time.

FOR DIVISION USE ONLY

Event Reason: ____

Effective Date: ____/____/____

Location No.: ____ ____

I certify that all the information supplied on this form is true to the best of my knowledge.

_____ _____

Applicant Signature *Date*