NJDPB Pensions & Benefits
Explore Your Benefits

NEW JERSEY ACTIVE EMPLOYEE DENTAL PLANS
ENROLLMENT *and/or* CHANGE FORM

HD-0719-0717
Division of Pensions & Benefits
P.O. Box 299
Trenton, NJ 08625-0299

1. EMPLOYEE INFORMATION — Employee Name ***(last, first)***

Gender	Birth Date	Social Security Number	Marital Status*
	_____/_____/_____	– –	

Telephone Number	Personal E-mail Address
( )	

Street Address

City | State | Zip

DIVISION USE ONLY

Effective Dates: Event Reason:
D _____ _____ _____

EMPLOYER CERTIFICATION
See instructions on reverse

Employer Name: _____

Payroll # (State Biweekly) ☐☐☐☐

Union Code (Rx) Only ☐☐

Location # (State Monthly or Local/Education) ☐☐☐☐-☐☐

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

_____/_____/_____ (mm/dd/yy)

Telephone #_____

2. REASON FOR APPLICATION ***(check one)***

☐ New Enrollment ☐ Transfer
☐ Open Enrollment ☐ Loss of Coverage
☐ Adding Dependents ☐ Deleting Dependents
☐ Waiver of Coverage ☐ Other

Reason_____

Date of Event _____/_____/_____

3. LEVEL OF COVERAGE

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

☐ I have been offered the above dental coverage and **I elect to waive participation** for myself and my eligible dependents.*

4. DENTAL PLAN You must remain enrolled in selected plan for 12 months.

☐ I wish to be covered under the Dental Expense Plan (Aetna DEP)*

☐ I wish to be covered under a Dental Plan Organization (DPO)* *(check one DPO plan below and add provider ID#)*

☐ Aetna DMO ☐ Cigna ☐ MetLife ☐ Healthplex ☐ Horizon BCBSNJ

ID # _____

5. Dependent Information: List all eligible dependents and attach required proof of dependency documents.*
Any dependents not listed will be removed.

Eligible Dependents Last Name, First Name	Social Security No.	Circle Relationship	Birth Date	Gender
	– –	Spouse/Civil Union Domestic Partner	/ /	
	– –	Child *(Natural, Adopted, Foster, Step, Legal Ward)*	/ /	
	– –	Child *(Natural, Adopted, Foster, Step, Legal Ward)*	/ /	
	– –	Child *(Natural, Adopted, Foster, Step, Legal Ward)*	/ /	

**** See Instructions page for detailed information***

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 understand that I must remain enrolled in the Dental Plan for a minimum of 12 months and that there is no guarantee of continuous participation by dental service providers, either dentists or facilities, in the DPO plans. If either my dentist or dental center terminates participation in my selected plan, I must select another dentist or dental center participating in that plan to receive the "in-network" benefit. I authorize any hospital, physician, dentist or dental care provider to furnish my dental plan or its assignee with such dental 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 pursuant to N.J.S.A.17:33A-6c.

6. Employee Signature:_____ **Date:** _____/_____/_____

INSTRUCTIONS FOR THE NEW JERSEY EMPLOYEE DENTAL PLANS ENROLLMENT and/or CHANGE FORM

SECTION 1 – EMPLOYEE INFORMATION – Complete entire section. Indicate **Marital Status** as follows: **S** (Single), **M** (Married), **C** (Civil Union), **DP** (Domestic Partner), **D** (Divorced), **W** (Widowed)

SECTION 2 – REASON FOR APPLICATION – Check one block only

- **New Enrollment** – New hire or HIPAA event
- **Transfer** – Active dental benefits coverage transferring from another SHBP/SEHBP location
- **Open Enrollment** – Annually in October
- **Adding Dependents** – Must be done within 60 days of event (i.e. birth, marriage, adoption – indicate reason and date)
- **Deleting Dependents** – Removal of covered dependents (indicate reason and date)
- **Loss of Coverage** – Enrolling because of loss of other coverage (application and HIPAA certificate submitted within 60 days of the loss of other coverage)
- **Waiver of Coverage** – Waive (decline) coverage
- **Other** (indicate reason and date)
- **Reason** – indicate reason
- **Date of Event** – indicate date

To waive (decline) coverage: If you wish to waive Dental coverage under the provisions of N.J.S.A. 52:14-17.31a, check appropriate block. If you are waiving coverage for yourself or any or all of your eligible dependents because of other group health coverage, you may enroll in the future. You must provide proof of the loss of other coverage and submit it with your application within 60 days of the loss of other coverage. Otherwise you will be required to wait until the annual Open Enrollment.

SECTION 3 – LEVEL OF COVERAGE – Indicate by checking the appropriate block

- **Single** – coverage for you only
- **Parent/Child(ren)** – coverage for you and any eligible child(ren) under age 26
- **Member/Spouse/Civil Union** – coverage for you and your spouse or your Civil Union Partner
- **Member/Domestic Partner** – coverage for you and your Domestic Partner
- **Family** – coverage for you, your eligible Spouse/Civil Union Partner/Domestic Partner, and child(ren) under age 26

SECTION 4 – DENTAL PLAN – Select only one plan. The *Employee Dental Plans Member Handbook* provides you with all available options at ***www.state.nj.us/treasury/pensions/handbooks.shtml*** If you enroll in a **Dental Plan Organization (DPO)** you must receive services from an in-network dentist in order to have your claims paid. You must select a participating dentist within the DPO, ensuring the dentist or facility takes new patients and participates with the Employee Dental Plans. If you enroll in the **Dental Expense Plan (Aetna DEP)** you may receive services from any dentist. You will be required to pay up-front for covered services until a deductible is met.

IMPORTANT: After you enroll in a Dental Plan you must remain enrolled for 12 months until you are permitted to terminate coverage.

SECTION 5 – DEPENDENT INFORMATION – List all eligible dependents and attach dependent documentation proof (see attached). If proper documentation has already been provided and approved, do not resubmit. If appropriate dependent documentation proof is not provided, dependents may not be enrolled. Ensure your dependents match your level of coverage (Section 4). Your child(ren) may be covered until the end of the calendar year they turn 26. **ANY DEPENDENTS NOT LISTED WILL NOT BE COVERED.**

Note: Use Section 2 to delete dependents

SECTION 6 – EMPLOYEE SIGNATURE – Read, sign, date, and attach required dependent documentation. Return the application to your employer's Human Resources office for certification.

MISREPRESENTATION: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties pursuant to N.J.S.A. 17:33A-6c.

EMPLOYER CERTIFICATION – Must be completed by the Certifying Officer. The Certifying Officer's signature confirms that:

- The employee is eligible;
- The application is legible and completed in its entirety;
- The employee's selected plans and coverage levels are appropriate;
- The dependent documentation provided is complete and correct;
- The Employer Certification section is completed in its entirety; and
- The information presented is true to the best of their knowledge.