HR-0976-0218

State Health Benefits Program (SHBP) • School Employees' Health Benefits Program (SEHBP)

CANCEL/DECLINE/WAIVE RETIRED COVERAGE FORM

MEMBER INFORMATION — Last Name | First | MI

Gender	Birth Date	Social Security Number	Marital Status*
	/ /	— —	

Telephone Number	Personal E-mail Address
( )	

Street Address | *City* | *State* | *Zip*

FORMER EMPLOYER NAME_____

DATE OF RETIREMENT _____/_____/_____

CANCEL/DECLINE COVERAGE — *For those who permanently DO NOT want coverage*

☐ I wish to cancel/decline my SHBP/SEHBP coverage. I understand that I will not be permitted to enroll in the SHBP/SEHBP at a later date.

Check applicable box: ☐ **Medical Only** ☐ **Dental Coverage Only** ☐ **Both Medical and Dental Coverage**

If you are currently enrolled in the SHBP/SEHBP Medical and/or Dental Plan and you wish to **cancel** one or both types of coverage, check appropriate block. If you are newly eligible to enroll and wish to **decline** SHBP/SEHBP Medical and/or Dental coverage, check appropriate block. If you are declining only one type of coverage, you must also complete *a Retiree Health Benefit Enrollment and/or Change Form* or a *Retiree Dental Plan Application* to enroll in the coverage of your choice. **Note:** If you cancel or decline Medical coverage, you will not be permitted to enroll in the SHBP/SEHBP Medical plan at a later date. If you cancel or decline Dental coverage only, you will not be permitted to enroll in the SHBP/SEHBP Dental plans at a later date. Your enrollment in Medical coverage will not be affected.

WAIVE COVERAGE — *For those who have other coverage and may wish to enroll later*

☐ I am enrolled in another group plan and wish to waive coverage (you cannot waive SHBP/SEHBP coverage for a private plan). In order to enroll with the SHBP/SEHBP at a later date, I understand that must submit a *Retiree Health Benefit Enrollment and/or Change Form*, and/or a *Retiree Dental Plan Application* along with the proof of coverage loss, within 60 days of losing the other coverage.

Check applicable box: ☐ **Medical Only** ☐ **Dental Coverage Only** ☐ **Both Medical and Dental Coverage**

If you are currently enrolled in the SHBP/SEHBP Medical and/or Dental Plan and wish to waive one or both types of coverage, check appropriate block. This is the only form you will need to submit. If you are newly eligible to enroll and wish to waive SHBP/SEHBP Medical and/or Dental Coverage, check appropriate block. If you are waiving only one type of coverage, you must also complete a *Retiree Health Benefit Enrollment and/or Change* Form or a *Retiree Dental Plan Application* to enroll in the coverage of your choice.

WAIVE PRESCRIPTION COVERAGE — *For Medicare-eligible members only*

☐ I elect to waive Prescription Drug Coverage for participation in another Medicare Part D Plan.

If you are eligible for Medicare and wish to waive the SHBP/SEHBP Medicare Part D plan, you **must** attach written proof of your enrollment in another Medicare Part D plan.

***** Indicate **Marital Status** as follows: **S** (Single), **M** (Married), **CU** (Civil Union), **DP** (Domestic Partnership), **D** (Divorced), **W** (Widowed)

MAIL COMPLETED APPLICATION TO:

New Jersey Division of Pensions & Benefits ● Health Benefits Bureau ● P.O. Box 299 ● Trenton, NJ 08625-0299

FOR DIVISION USE ONLY

Event Reason: ☐

Effective Date

_____/_____/_____

Location No.

☐☐☐☐ ☐☐

MEMBER CERTIFICATION – I certify that all the information supplied on this form is true to the best of my knowledge. **MISREPRESENTATION:** Any person that knowingly provides false or misleading information is subject to criminal and civil penalties.

Member Signature:_____ **Date:** ____/____/____