HR-1018-0918

State Health Benefits Program (SHBP)

STATE/LOCAL GOVERNMENT RETIREE

HEALTH BENEFIT DISABILITY APPLICATION

NON-MEDICARE ENROLLEES

1. EMPLOYEE INFORMATION — Last Name | First | MI

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

Telephone Number ( )

Personal Email Address

Home Address No. and Street Name

City | State | Zip

When you submit your application, the SHBP will enroll you on the 1st of the month following the date of your Board approval.
If you wish to enroll retroactively (up to a maximum of 1 year) please check this block. ☐ *(You will be charged retroactively for any health and dental premiums.)*

2. FORMER EMPLOYER NAME _____

DATE OF RETIREMENT _____/_____/_____ Were you a part-time employee when you retired? ☐ Yes ☐ No

3. TYPE and LEVEL OF COVERAGE

Level	Health	Dental
☐ Single	☐	☐
☐ Parent/Child	☐	☐
☐ Member/Spouse/Civil Union	☐	☐
☐ Member/Domestic Partner	☐	☐
☐ Family	☐	☐

4. LEVEL OF MEDICARE COVERAGE — PART A *(Hospital Insurance)* Part B *(Medical Insurance)*

Do you have Part A ? ☐ Yes ☐ No Part B ? ☐ Yes ☐ No

Does your spouse/partner have Part A? ☐ Yes ☐ No Part B ? ☐ Yes ☐ No

Does your child have Medicare? ☐ Yes ☐ No

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.

5. HEALTH PLAN COVERAGE *(Check one box only)*

HORIZON

- ☐ NJ DIRECT15*
- ☐ NJ DIRECT10* *(local government only)*
- ☐ NJ DIRECT1525
- ☐ NJ DIRECT2030
- ☐ Horizon HMO
- ☐ Horizon HMO1525
- ☐ Horizon HMO2030

AETNA

- ☐ Aetna Freedom15*
- ☐ Aetna Freedom10* *(local government only)*
- ☐ Aetna Freedom1525
- ☐ Aetna Freedom2030
- ☐ Aetna HMO*
- ☐ Aetna HMO1525*
- ☐ Aetna HMO2030

For HMO Plans, Enter Primary Care Physician's ID# _____

*Medicare eligible spouses/partners will be placed in a corresponding Aetna Medicare Advantage Plan.

Note: Medicare eligible spouses/partners cannot be enrolled in Aetna Freedom1525, Aetna Freedom2030, Aetna HMO2030, NJ DIRECT15 or NJ DIRECT10.

6. DENTAL COVERAGE/ DENTAL PLANS

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

I wish to be covered under a Dental Plan Organization (DPO)* ☐ Cigna ☐ MetLife ☐ Healthplex ☐ Horizon BCBSNJ ☐ Aetna DMO

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

7. DEPENDENT INFORMATION: List all eligible dependents and attach required proof of dependency documents.*

☐ **Additional sheets attached. 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)*	/ /	

***See Instructions page for detailed information and Mailing Address**

FOR DIVISION USE ONLY

Event Reason: ☐

Effective Date _____/_____/_____

Location No. ☐☐☐☐ ☐☐

EMPLOYEE CERTIFICATION — I certify that all the information supplied on this form is true to the best of my knowledge. I authorize a health premium 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. I also understand that there is no guarantee of continuous participation by medical service providers, either doctors or facilities in the plans. I authorize any hospital, physician, or health care provider to furnish my medical plan or its assignee with such medical information about myself, or my covered dependents on this application, as the assignee may require. **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.

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

INSTRUCTIONS FOR THE SHBP STATE/LOCAL GOVERNEMENT RETIREE HEALTH BENEFITS ENROLLMENT and/or CHANGE FORM

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

SECTION 2 – Indicate your former employers name, your date of retirement and if you were a part-time employee when you retired.

SECTION 3 – TYPE AND LEVEL OF COVERAGE – Indicate your level of coverage and plan(s) in which you wish to enroll by checking the appropriate block(s).

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

SECTION 4 – LEVEL OF MEDICARE COVERAGE – Indicate whether you and/or your spouse/partner and/or child are enrolled in Medicare Parts A and B by checking the appropriate block(s). 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.

SECTION 5 – HEALTH PLAN – Indicate by checking the appropriate block(s). When choosing an HMO Plan, you must list the identification number (ID#) of your Primary Care Physician.

SECTION 6 – DENTAL PLAN – Select only one plan. The *Employee Dental Plans Member Guidebook* provides you with all available options at ***www.state.nj.us/treasury/pensions/member-guidebooks.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.

To waive (decline) coverage: If you wish to waive Health and/or Dental coverage under the provisions of N.J.S.A. 52:14-17.31a, check appropriate block(s). 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.

SECTION 7 – 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.**

SECTION 8 – EMPLOYEE SIGNATURE – Read, sign, and date the application.

MISREPRESENTATION: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties.

MAIL COMPLETED APPLICATION TO:

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

HB-0840-1217

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

REQUIRED DOCUMENTATION FOR 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, and eligible dependents are receiving health care coverage under the Programs. The New Jersey Division of Pensions & Benefits (NJDPB) must guarantee consistent application of eligibility requirements within the plans. Employees or retirees who enroll dependents for coverage (spouses, civil union partners, domestic partners, children, disabled and/or overage children continuing coverage) MUST submit the following documentation in addition to the appropriate health benefits enrollment or change of status application. 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. **ANY DEPENDENTS NOT LISTED ON THE APPLICATION WILL NOT BE COVERED.**

DEPENDENTS	ELIGIBILITY DEFINITION	DOCUMENTATION REQUIRED
SPOUSE	A person to whom you are legally married.	A copy of the marriage certificate **and** a copy of the front page of the employee/retiree's federal tax return* (Form 1040) from last year that includes the spouse. If filing separately, submit a copy of both spouses' tax returns that list the same address. If marriage occurred in the current calendar year, a copy of the tax return is not required. **Or**, if tax return is not available, provide a copy of a bank statement or bill (dated within 90 day of the application) that includes the names of both spouses and is received at the same address.
CIVIL UNION PARTNER	A person of the same sex with whom you have entered into a civil union.	A copy of the marriage certificate **and** a copy of the front page of the employee/retiree's federal tax return* (Form 1040) from last year that includes the partner. If filing separately, submit a copy of both partners' tax returns that list the same address. If marriage occurred in the current calendar year, a copy of the tax return is not required. **Or**, if tax return is not available, provide a copy of a bank statement or bill (dated within 90 day of the application) 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 P.L. 2003, c. 246, 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 copy of the New Jersey certificate of domestic partnership dated prior to February 19, 2007, or a valid certification from another State or foreign jurisdiction that recognizes same-sex domestic partners **and** a copy of the front page of the employee/retiree's N.J. tax return* from last year that includes the partner. If filing separately, submit a copy of both partners' NJ tax returns that list the same address. If Domestic Partnership occurred in the current calendar year, a copy of the tax return is not required. **Or**, if tax return is not available, provide a copy of a bank statement or bill (dated within 90 days of the application) that includes the names of both partners and is received at the same address.
CHILDREN	A subscriber's child until age 26, regardless of the child's marital, student, or financial dependency status – even if the young adult no longer lives with his or her parents. This includes a stepchild, foster child, legally adopted child, or any child in a guardian-ward relationship upon submitting required supporting documentation.	**Natural or Adopted Child** – A copy of the child's birth certificate showing the name of the employee/retiree as a parent. **Step Child** – A copy of the child's birth certificate showing the name of the employee/retiree's spouse or partner as a parent **and** a copy of the marriage/partnership certificate showing the names of the employee/retiree and spouse/partner. **Legal Guardian, Grandchild, or Foster Child** – Copies of final court orders with the presiding judge's signature and seal. Documents must attest to the legal guardianship by the employee.
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; (2) the child continues to be disabled; (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.	Documentation for the appropriate "child" type (as noted above) **and** a copy of the front page of the employee/retiree's federal tax return* (Form 1040) from last year that includes the child. If Social Security disability has been awarded, or is currently pending, please include this information with the documentation that is submitted. 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.
CONTINUED COVERAGE FOR OVERAGE CHILDREN	Certain children over age 26 may be eligible for continued coverage until age 31 under the provisions of P.L. 2005, c. 375. 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 copy of the front page of the child's federal tax return* (Form 1040) from last year, and if the child resides outside of the State of New Jersey, documentation of full time student status must be submitted.

*You may black out all financial information and all but the last four digits of any Social Security numbers on tax returns. 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 websites: ***www.vitalrec.com*** or ***www.studentclearinghouse.org*** Residents of New Jersey can obtain records from the State Bureau of Vital Statistics and Registration website: ***www.nj.gov/health/vital/index.shtml***