



State Health Benefits Program (SHBP)
CWA EMPLOYEES — STATE ACTIVE EMPLOYEE GROUP
HEALTH BENEFITS ENROLLMENT AND/OR CHANGE FORM

1. MEMBER INFORMATION — Last Name				First	MI	DIVISION USE ONLY																			
Gender	Birth Date / /	Social Security Number — —	Marital Status*			Effective Dates H ___/___/___ Rx ___/___/___	Event Reason: <input type="checkbox"/>																		
Phone Number ()		Email Address				EMPLOYER CERTIFICATION (See Instructions on reverse)																			
Street Address		City	State	Zip		Employer Name _____	Payroll # _____ (State Biweekly)																		
						Union Code (Rx) Only <input type="checkbox"/>	Location # (State Monthly) <input type="checkbox"/>																		
2. EMPLOYMENT STATUS			3. REASON FOR APPLICATION (Check one)			4. TYPE AND LEVEL OF COVERAGE																			
<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Intermittent <input type="checkbox"/> National Guard <input type="checkbox"/> ACA (Monthly only)			<input type="checkbox"/> New Enrollment <input type="checkbox"/> Transfer <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Adding Dependents <input type="checkbox"/> Deleting Dependents <input type="checkbox"/> Waiver of Coverage <input type="checkbox"/> Other Reason _____ Date of Event ___/___/___			<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="text-align: left;">Level</th> <th style="text-align: center;">Health</th> <th style="text-align: center;">Rx</th> </tr> <tr> <td><input type="checkbox"/> Single</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Parent/Child</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Member/Spouse/Civil Union</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Member/Domestic Partner</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Family</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		Level	Health	Rx	<input type="checkbox"/> Single	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Parent/Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Member/Spouse/Civil Union	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Member/Domestic Partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Family	<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/> Family	<input type="checkbox"/>	<input type="checkbox"/>																							
I have been offered the above coverage and I elect to waive participation for myself and my eligible dependents (see Instructions page for details). Note: Oral contraceptive coverage is available under the medical plan.						10/12 - month employee (Enter 10 or 12) <input type="checkbox"/> MEMBER ACTION <input type="checkbox"/> New Enrollment <input type="checkbox"/> Transfer Date Employment Began ___/___/___ <input type="checkbox"/> Return from Leave of Absence ___/___/___																			
<input type="checkbox"/> I elect to waive Health Coverage <input type="checkbox"/> I elect to waive Prescription Drug Coverage						_____ <i>Signature of Certifying Officer</i>																			
						Phone Number	Date Mailed																		

5. HEALTH PLAN — Check one box only.

OMNIA Health Plan*1
 CWA Unity DIRECT/CWA Unity DIRECT2019*
 Horizon HMO
 NJ DIRECT HD1500*
 NJ DIRECT HD4000

I have chosen the OMNIA Health Plan and wish to waive my financial incentive.

For HD Plans only – Health Savings Account (HSA)

I wish to establish an HSA at this time and understand that I will be contacted to establish banking. By applying for and funding my HSA I represent that I:

- 1) am covered under a High Deductible Health Plan (HDHP);
- 2) am not covered by any other non-HDHP product;
- 3) am not covered by Medicare; and
- 4) cannot be claimed as a dependent on another person's tax return.

I am not enrolling in an HSA at this time and understand that if I choose to at a later date, I must contact my health plan.

6. DEPENDENT INFORMATION — List all eligible dependents and attach required proof of dependency documents*				
<input type="checkbox"/> 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 <i>(Natural, Adopted, Foster, Step, Legal Ward)</i>	/ /	
	— —	Child <i>(Natural, Adopted, Foster, Step, Legal Ward)</i>	/ /	
*See Instructions page for detailed information and mailing address				

MEMBER 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 also understand that there is no guarantee of continuous participation by medical providers, either doctors or facilities, in the plans. If either my physician or medical center terminates participation in my selected plan, I must select another doctor or medical center participating in that plan to receive the in-network benefit. 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 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.

7. Member Signature _____ **Date** ___/___/___

**INSTRUCTIONS FOR THE SHBP STATE ACTIVE EMPLOYEE GROUP — CWA EMPLOYEES
HEALTH BENEFITS ENROLLMENT AND/OR CHANGE FORM**

SECTION 1 – MEMBER 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 – EMPLOYMENT STATUS – Check one box only

SECTION 3 – REASON FOR APPLICATION – Check one box only

- **New Enrollment** – New hire or HIPAA event
- **Transfer** – Active health 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 Health and/or Prescription Drug coverage under the provisions of N.J.S.A. 52:14-17.31a, check appropriate box. **Note:** Both Health and Prescription Drug coverage must be waived to avoid paying a contribution. 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 4 – TYPE AND LEVEL OF COVERAGE – Check the appropriate box to enroll in Health and/or Rx (Prescription Drug)

- **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 5 – HEALTH PLAN – Select only one plan. The Health Benefits *Summary Program Description* provides you with all available options. Members who wish to enroll in a High Deductible Health Plan (HDHP) must complete a *Health Savings Account (HSA) Form*. Guidebooks and applications can be found on our website at www.nj.gov/treasury/pensions

* First-time enrollees who choose the OMNIA Health plan are entitled to a financial incentive if they remain in the plan for one year. Members can choose to waive this benefit by checking the waiver box under the plan selections.

* Members hired before July 1, 2019 will be enrolled in NJ DIRECT. Members hired after July 1, 2019 will be enrolled in NJ DIRECT 2019.

* Part-time employees cannot enroll in the NJ DIRECT HD1500 Plan.

SECTION 6 – 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. Attach extra pages for additional dependents.

Note: Use Section 3 to delete dependents.

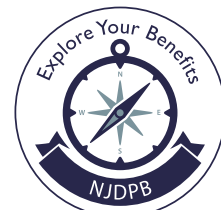
SECTION 7 – MEMBER SIGNATURE – Read, sign, date, and attach required dependent documentation. Return the application to your employer's human resources office for certification.

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.

MAIL COMPLETED APPLICATION TO: **New Jersey Division of Pensions & Benefits
Health Benefits Bureau
P.O. Box 299
Trenton, NJ 08625-0299**



HA-1044-0220



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. 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. 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. 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 Ward, 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