If Enrolling a Dependent, see the Documentation Requirements

PART-TIME EMPLOYEES GROUP — NEW JERSEY STATE HEALTH BENEFITS PROGRAM APPLICATION

HA-0802-0909p

Division of Pensions and Benefits, P.O. Box 299, Trenton, NJ 08625-0299

1. EMPLOYEE INFORMATION — This section must be filled out *completely*. Please print or type.

Social Security Number ___ — __ — ____

Last Name ____ Title (Jr.,Sr., etc.) ____

First Name ____ MI ____

Street Address (Include Apartment #) ____

City ____ State ____

Zip Code + 4 ____ — ____ Date of Birth (mm/dd/yy) ____ Gender (M/F) ____

Status: ☐ - Single ☐ - Married ☐ - Civil Union ☐ - Domestic Partnership ☐ - Divorced ☐ - Widowed

(Area Code) Home Telephone Number ___ — ___ — ____

Are you transferring your health benefits from another SHBP participating employer?

No ☐ Yes ☐ If yes, name of employer _____

2. MEDICAL COVERAGE

2a. EMPLOYEE SELECTION

☐ I wish to be covered under NJ DIRECT15 **and** the Employee Prescription Drug Plan.

☐ I wish to be covered under NJ DIRECT15 **only** and *waive* Employee Prescription Drug Plan coverage.

2b. LEVEL OF NJ DIRECT15 COVERAGE

☐ - Single ☐ - Member & Spouse/Civil Union Partner ☐ - Family

☐ - Member & Domestic Partner – (see instructions) ☐ - Parent & Child(ren)

2c. LEVEL OF EMPLOYEE PRESCRIPTION DRUG COVERAGE

☐ - Single ☐ - Member & Spouse/Civil Union Partner ☐ - Family

☐ - Member & Domestic Partner – (see instructions) ☐ - Parent & Child(ren)

3. WAIVER OF COVERAGE

☐ I elect to **waive** medical and prescription drug coverage for myself and for my dependents (see instructions).

4. DEPENDENT INFORMATION — *List all eligible dependents and attach required proof of dependency documents (see instructions on reverse).*

	Last Name	First Name	MI	Date of Birth Month Day Year	Gender (M/F)	Social Security Number	Natural (C) Adopted (A) Step (S) Foster (F) Legal Ward (L) (See Instructions)
☐ **Spouse/Partner**							
Children							

5. TYPE OF ACTIVITY (complete only if requesting changes to existing coverage)

5a. ADDITION OF DEPENDENT

☐ Marriage - Date of Event (Mo/Day/Yr) _____
(Copy of Marriage Certificate required)

Former Name _____

☐ Civil Union/Domestic Partner - Date of Event (Mo/Day/Yr) _____
(Copy of Civil Union or Domestic Partnership Certificate required)

☐ Birth of Child ☐ Adoption/Guardianship — Proof Required

Date of Event (Mo/Day/Yr) _____

5b. DELETION OF SPOUSE OR PARTNER

☐ Separation ☐ Divorce ☐ Dissolution of Civil Union

☐ Termination of Domestic Partnership ☐ Death of Spouse/Partner

Date of Event (Mo/Day/Yr) _____

5c. DELETION OF CHILD

☐ Deletion of Child - Date of Event (Mo/Day/Yr) _____

Child's Name _____

Child's SSN _____

Give Reason _____

5d. OTHER CHANGES

☐ Change in last name only

(List Former Name) _____

☐ Change in Soc. Sec. # *(Attach copy of Social Security card)*

(List Former Soc. Sec. #) _____

☐ Change in Birth Date *(Attach copy of birth certificate)*

(List Name and Correct Date) _____

☐ Other - give reason (*i.e.*, address change, dependent returns from military service)

_____

_____

_____

DIVISION USE ONLY

Effective Dates: ____ ____ ____ ____ ____ ____

Event Reason: ____

EMPLOYER CERTIFICATION

To Be Completed By Employer

Employer Name: _____

Location # ____ 7 0

STATE ONLY: Payroll # ____ Union Code (Rx) Only ____

MEMBER ACTION:

☐ **New Enrollment** — Must be completed

List Date of Pension Enrollment (Mo/Day/Yr)_____/_____/_____

OR

Pension Number _____ — _____

☐ **Transfer** Date _____/_____/_____

Name of Former Employer _____

☐ **Return from Leave of Absence** _____/_____/_____ (Mo/Day/Yr)

10/12 month employee ____

EMPLOYER CERTIFICATION — I certify that this part-time employee is eligible for enrollment under the provisions of Chapter 172, P.L. 2003, and that the information supplied on this form is true to the best of my knowledge.

_____
Signature of Certifying Officer

_____
Telephone # Date Mailed

6. Employee Certification

— I certify that all the information supplied on this form is true to the best of my knowledge. I authorize the Division of Pensions and Benefits to bill me for monthly premium payments as required by the provisions of Chapter 172, P.L. 2003. I understand that if I waive my right to coverage at this time, enrollment is not normally 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 in-network participation by medical service providers, either doctors or facilities in the NJ DIRECT15 plan. If either my physician or medical center terminates participation in NJ DIRECT15, I must select another doctor or medical center participating in NJ DIRECT15 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.

_____ _____
Employee's Signature Date Completed

COMPLETING THE PART-TIME EMPLOYEES GROUP NJ STATE HEALTH BENEFITS PROGRAM APPLICATION

QUICK REFERENCE

- This application is for use by part-time State employees and part-time faculy members at a state college or university, or county or community college who are eligible for State Health Benefits Program coverage under Chapter 172, P.L. 2003. For more information about this law and the eligibility requirements for Part-time employees, see Fact Sheet #66, *SHBP Coverage for State Part-time Employees.*
- To **enroll** for the first time complete all sections of the application with the exception of section 5.
- To **change coverage level** (adding/deleting dependents) complete sections: 1, 2a, 2b, and 2c (if applicable), 4, (be sure to list **all** eligible dependents), 5 (listing why you are changing coverage level), and 6.
- To **add a dependent** complete sections: 1, 2a, and (as applicable) 2b and/or 2c, 4 (list all eligible dependents), 5a, and 6. You must also attach required proof of dependency documentation.
- To **terminate/decline coverage** complete sections: 1, and either 2a and 2b to terminate/decline prescription drug coverage only **or** 3 to waive **all** coverage, and 6. Note: If you are declining enrollment for yourself or any or all of your eligible dependents because of other group health insurance coverage, you may in the future be able to enroll yourself and/or your eligible dependents in a SHBP medical plan, provided that you request enrollment within 60 days after your other group health coverage ends.

SECTION 1 — EMPLOYEE INFORMATION

This section must be completed in its entirety each time an application is submitted. The employee enrolling or enrolled in the plan completes this section.

SECTION 2 — MEDICAL COVERAGE

2a. **Check only one box** indicating if you want NJ DIRECT15 **and** Employee Prescription Drug Plan coverage or NJ DIRECT15 coverage **only**.

2b. Check the NJ DIRECT15 coverage level desired.

2c. If you are selecting prescription drug coverage, check the Employee Prescription Drug Plan coverage level desired.

SPOUSE: This is a person of the opposite sex to whom you are legally married. A photocopy of the *Marriage Certificate* **and** a photocopy of the employee's most recent Federal tax return* that includes the spouse are required for enrollment.

CIVIL UNION PARTNER: This is a person of the same sex with whom you have entered into a civil union. A photocopy of the New Jersey *Civil Union Certificate* or a valid certification from another jurisdiction that recognizes same-sex civil unions **and** a photocopy of the employee's most recent NJ tax return* that includes the partner are required for enrollment. The cost of civil union partner coverage may be subject to federal tax (see your employer or Fact Sheet #75, *Civil Unions,* for details).

DOMESTIC PARTNER: This is a same-sex domestic partner, as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act, of any State employee, State retiree, or an eligible employee or retiree of a SHBP participating local public entity if the local governing body adopts a resolution to provide Chapter 246 health benefits. A photocopy of the New Jersey *Certificate of Domestic Partnership* dated prior to February 19, 2007 or a valid certification from another jurisdiction that recognizes same-sex domestic partners **and** a photocopy of the employee's most recent NJ tax return* that includes the partner are required for enrollment. The cost of same-sex domestic partner coverage may be subject to federal tax (see your employer or Fact Sheet #71, *Benefits Under the Domestic Partnership Act,* for details).

***Note:** On tax forms you may black out all financial information and all but the last 4 digits of any Social Security numbers.

SECTION 3 — WAIVER OF COVERAGE

If you do not want coverage under Chapter 172, check this box.

Note: Once you decline or cancel coverage, enrollment is not normally permissible until the next open enrollment period or if other coverage is lost and proof of loss is provided (HIPAA).

SECTION 4 — DEPENDENT INFORMATION

Only eligible dependents may be listed. Completion of this section is essential for proper enrollment. Be sure dependents listed agree with the level of coverage selected in sections 2b and 2c. List the name, date of birth, gender, and Social Security number of the family members you wish to be covered under the plan. You may cover an eligible spouse, civil union partner, or eligible same-sex domestic partner (as defined in Section 2, above). A photocopy of a child's birth certificate is required for enrollment. In addition, if you have listed a child who is an adopted child, foster child, stepchild, legal ward, has a different last name than the employee, or if the member has a Parent/Child contract, proof of dependency documentation is required. If you are divorced, your children who do not live with you are eligible if you are legally required to support those children. An *Affidavit of Dependency* form may also be required. If you have more than 4 eligible dependent children, attach a separate application and complete Sections 1, 4, and 6.

Note: If you are deleting dependents, do not list them in this section. Refer to section 5b and 5c.

SECTION 5 — TYPE OF ACTIVITY

5a. If you are adding a dependent, check the appropriate box and the event date.

5b. If you are deleting a dependent spouse/partner, check reason and indicate the event date.

5c. If you are deleting a dependent child, indicate the event date, list the child's Social Security number, and give reason.

5d. For other changes, check the appropriate box and give reason.

SECTION 6 — EMPLOYEE CERTIFICATION

You must read the Employee Certification statement, **sign it, and date the application.**

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

EMPLOYER CERTIFICATION

Must be completed by your employer. This application must be certified by the employer before submitting it to the SHBP. The Certifying Officer should:

1) Verify the employee's eligibility;
2) Verify that the application is legible and completed in its entirety;
3) Verify that the employee's selected plans and coverage levels are appropriate; and
4) Complete the Employer Certification section in its entirety.

For New Enrollments: The employer must provide the employee's Date of Pension Enrollment (if employee is a new enrollee, enter expected enrollment date based upon submission of the pension Enrollment Application) or the employee's Pension Membership Number.

HB-0840-0909

REQUIRED DOCUMENTATION FOR SHBP/SEHBP 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 their eligible dependents are receiving health care coverage under the programs. As a result, the Division of Pensions and Benefits 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 dependents, and over age children continuing coverage) must submit the following documentation in addition to the appropriate health benefits enrollment or change of status application.

DEPENDENTS	ELIGIBILITY DEFINITION	DOCUMENTATION REQUIRED
SPOUSE	A person of the opposite sex to whom you are legally married.	A photocopy of the *Marriage Certificate* **and** a photocopy of the top half of the front page of the employee/retiree's most recently filed federal tax return* (*Form 1040*) that includes the spouse.
CIVIL UNION PARTNER	A person of the same sex with whom you have entered into a civil union.	A photocopy of the *New Jersey Civil Union Certificate* or a valid certification from another jurisdiction that recognizes same-sex civil unions **and** a photocopy of the top half of the front page of the employee/retiree's most recently filed New Jersey tax return* that includes the partner **or** a photocopy of a recent (within 90 days of application) bank statement or bill 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 Chapter 246, P.L. 2003, 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 photocopy of the *New Jersey Certificate of Domestic Partnership* dated prior to February 19, 2007 or a valid certification from another State of foreign jurisdiction that recognizes same-sex domestic partners **and** a photocopy of the top half of the front page of the employee/retiree's most recently filed New Jersey tax return* that includes the partner **or** a photocopy of a recent (within 90 days of application) bank statement or bill that includes the names of both partners and is received at the same address.
CHILDREN	Your unmarried children under age 23 who: live with you in a regular parent-child relationship; are away at school; or are divorced children living at home provided that they are dependent upon you for support and maintenance. If you are a single parent, divorced, or legally separated, your children who do not live with you are eligible if you are legally required to support those children. Stepchildren, foster children, legally adopted children, and children in a guardian-ward relationship are also eligible provided they live with you, are under the age of 23, and are substantially dependent upon you for support and maintenance.	**Natural Child** – A photocopy of the child's birth certificate showing the name of the employee/retiree as a parent. **Step Child** – A photocopy of the child's birth certificate showing the name of the employee/retiree's spouse or partner as a parent **and** a photocopy of the marriage/partnership certificate showing the names of the employee/retiree and spouse/partner. **Legal Guardian, Adoption, Grandchild(ren), or Foster Child(ren)** – Photocopies of Affidavits of Dependency, Final Court Orders with the presiding judge's signature and seal, **or** Adoption Final Decree with the presiding judge's signature and seal.
DEPENDENT CHILDREN WITH DISABILITIES	If a covered child is not capable of self-support when he or she reaches age 23 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, and (2) the child continues to be disabled, and (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" dependent type as noted above **and** a photocopy of the top half of the front page of the employee/retiree's most recently filed federal tax return* (*Form 1040*) that includes the child If Social Security disability has been awarded, or is currently pending, please include this information in the documentation 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 OVER AGE CHILDREN	Certain dependent children may be eligible for continued coverage under the provisions of Chapter 375, P.L. 2005. 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" dependent type as noted above **and** a photocopy of the top half of the front page of the employee/retiree's most recently filed federal tax return* (*Form 1040*) that includes the child **or** if the over age child is not listed on the employee/retiree's tax return, a copy of the top half of the child's most recently filed tax return* is required **and** if the child resides outside of the State of New Jersey, documentation of full-time student status must be provided.

***Note:** *For tax forms you may black out all financial information and all but the last 4 digits of any Social Security numbers.*

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 Web sites: ***www.vitalrec.com*** or ***www.studentclearinghouse.org***
Residents of New Jersey can obtain records from the State Bureau of Vital Statistics and Registration Web site: ***www.state.nj.us/health/vital/index.shtml***