

INSTRUCTIONS FOR THE NJ STATE HEALTH BENEFITS PROGRAM APPLICATION STATE AND LOCAL EDUCATION/GOVERNMENT ACTIVE EMPLOYEE GROUP

- To change your primary care physician (PCP) with your HMO, contact your health plan directly. **DO NOT COMPLETE THIS FORM JUST TO CHANGE YOUR PRIMARY CARE PHYSICIAN.**
- To enroll for the first time, complete all sections of the application with the exception of section 5.
- To change health plans only complete sections: 1, 2a and 2b (If enrolling in an HMO be sure to list your primary care physician's identification number), 4 (listing all eligible dependents), and 6.
- To change coverage level (adding/deleting dependents) complete sections: 1, 2a and 2b, 3a and 3b (if SHBP prescription drug coverage is provided by your employer), 4 (listing all eligible dependents), 5 (listing why you are changing coverage level), and 6.
- To add a dependent complete sections: 1, 2a and 2b, 3a and 3b (if SHBP prescription drug coverage is provided by your employer), 4 (listing all eligible dependents), 5a, and 6.
- To terminate/decline coverage complete sections: 1, 2a and/or 3a (as applicable), and 6. (If you are eligible to waive coverage under the provisions of N.J.S.A. 62:14-17.31(a), you must also complete and attach the *Waiver/Reinstatement Declaration* form available from your employer.) 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 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 the medical plan you wish to be enrolled in. If you do not want medical coverage or wish to cancel coverage, check the box to waive coverage.

2b. If you are electing coverage, check the level of coverage desired.

SPOUSE: This is a person of the opposite sex to whom you are legally married. A photocopy of the *Marriage Certificate* is 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 is required for enrollment. The cost of a civil union partner's 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 is 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).

SECTION 3 - PRESCRIPTION DRUG COVERAGE

The Employee Prescription Drug Plan is available to State employees and to only Local/Educational employees whose employers have adopted a resolution to provide this coverage. If the Employee Prescription Drug Plan is provided by your employer:

3a. To enroll, check the box to indicate that you wish to be covered. If you do not want prescription drug coverage or wish to cancel coverage, check the box to waive coverage.

3b. If you are electing coverage, check the level of coverage desired. (If enrolling a domestic partner, see eligibility information in "Domestic Partner" under 2b above).

NOTE: Once you decline or cancel Medical or Prescription Drug coverage, enrollment is not 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 3b. List the name, date of birth, gender, and Social Security number of the family members you wish to cover under the plan. You may list an eligible spouse, civil union partner, or same-sex domestic partner (see definitions in Section 2, above). 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 is required (contact your payroll/personnel representative for an *SHBP Affidavit of Dependency* form). If you have more than four eligible dependent children, attach a separate application and complete Sections 1, 4, and 6. If enrolling in an HMO, include each dependent's HMO Primary Care Physician identification number — all dependents must have this information listed. Refer to the HMO plan's provider directory or Web site for this information, or call the HMO plan directly. Plan Web sites and phone numbers can be found on the *SHBP Plan Comparison Summary*.

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 indicate the event date.

5b. If you are deleting a dependent spouse, civil union partner, or domestic 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, give requested information, and attach a copy of supporting documentation if applicable.

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 before submitting the application to the SHBP. By signing this application the employer certifies that:

- 1) The employee is eligible;
- 2) The application is legible and completed in its entirety;
- 3) The employee's selected plans and coverage levels are appropriate;
- 4) The Employer Certification section is completed in its entirety; and
- 5) The information presented is true to the best of their knowledge.