PART-TIME EMPLOYEES GROUP — NEW JERSEY STATE HEALTH BENEFITS PROGRAM APPLICATION HA-0802-0108p

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 (see 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 Data) _____

☐ 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