

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

Social Security Number, Last Name, First Name, Street Address, City, State, ZIP Code, Date of Birth, Gender, Status, Home Telephone Number, Are you transferring your health benefits from another SHBP/SEHBP participating employer?

2. MEDICAL COVERAGE

2a. EMPLOYEE SELECTION: I wish to be covered under NJ DIRECT15, NJ DIRECT10, Aetna HMO, CIGNA HealthCare HMO. 2b. LEVEL OF COVERAGE: Single, Member and Spouse/Civil Union Partner, Member and Domestic Partner, Family, Parent and Child(ren).

3. PRESCRIPTION DRUG COVERAGE — See note below

3a. EMPLOYEE SELECTION: I wish to be covered by the Employee Prescription Drug Plan. 3b. LEVEL OF COVERAGE: Single, Member and Spouse/Civil Union Partner, Member and Domestic Partner, Family, Parent and Child(ren). Note: Prescription Drug coverage is available to all State employees...

DIVISION USE ONLY: Effective Dates, Event Reason, EMPLOYER CERTIFICATION, Employer Name, Payroll #, Union Code, Location #, 10/12 month employee, MEMBER ACTION, Date Employment Began, Return from Leave of Absence, Signature of Certifying Officer, Telephone #, Date Mailed.

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

Table with columns: Spouse/Civil Union/Domestic Partner, Children, Last Name, First Name, MI, Date of Birth, Gender, Social Security Number, Dependent's HMO Primary Care Physician ID#, Natural (C), Adopted (A), Foster (F), Step (S), Legal Ward (L), See Instructions.

5. TYPE OF ACTIVITY

(complete only if requesting changes to existing coverage)

5a. ADDITION OF DEPENDENT

Marriage - Date of Event, Civil Union/Domestic Partner - Date of Event, Birth of Child, Adoption/Guardianship - proof required.

5b. DELETION OF SPOUSE OR PARTNER

Divorce, Dissolution of Civil Union, Death, Termination of Domestic Partnership, Date of Event.

5c. DELETION OF CHILD

Deletion of Child - Date of Event, Child's Name, Child's SSN, Give Reason.

5d. OTHER CHANGES

Change in last name only, Change in Soc. Sec. #, Change in Birth Date, Other - give reason.

6. EMPLOYEE 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 NJ DIRECT and HMO plans.

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

Employee Signature, Date Completed

INSTRUCTIONS FOR THE HEALTH BENEFITS APPLICATION STATE AND LOCAL GOVERNMENT/EDUCATION ACTIVE EMPLOYEE GROUPS

- **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 Employee Prescription Drug Plan coverage is provided by your employer), 4 (list all eligible dependents), 5 (list why you are changing coverage level), and 6.
- **To add a dependent** complete sections: 1, 2a and 2b, 3a and 3b (if Employee Prescription Drug Plan coverage is provided by your employer), 4 (list all eligible dependents), 5a, and 6. You must also attach the required proof of dependency documents.
- **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. 52:14-17.31(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 or SEHBP 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* 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 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 - PRESCRIPTION DRUG COVERAGE

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

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). 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 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 *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, date the application, and attach any required proof for dependents.**

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 Health Benefits Bureau. 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.

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 <i>Marriage Certificate</i> and a photocopy of the top half of the front page of the employee/retiree's most recently filed federal tax return* (<i>Form 1040</i>) 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 <i>New Jersey Civil Union Certificate</i> 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 <i>New Jersey Certificate of Domestic Partnership</i> 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* (<i>Form 1040</i>) 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* (<i>Form 1040</i>) 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