

**SHBP & SEHBP  
CHAPTER 375 APPLICATION  
Coverage of a child up to age 31**

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

**1. COVERED CHILD'S INFORMATION** — Child's name (*last, first*)

|  |                                     |                                |
|--|-------------------------------------|--------------------------------|
| <b>Gender</b>  | <b>Birth Date</b><br>____/____/____ | <b>Social Security Number</b>  |
| <b>Telephone Number</b><br>(    )  |                                     | <b>Personal E-mail Address</b> |
| <b>Street Address</b>  |                                     |                                |
| <b>City</b>  | <b>State</b>                        | <b>Zip</b>                     |
| <b>Marital Status (Check One)</b>  |                                     |                                |
| <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Civil Union <input type="checkbox"/> Domestic Partnership |                                     |                                |
| <b>Relationship to Employee/Retiree (Check One)</b>  |                                     |                                |
| <input type="checkbox"/> Natural Child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Other ( <i>explain</i> ) _____   |                                     |                                |

**DIVISION USE ONLY**

Effective Dates

H \_\_\_\_\_

P \_\_\_\_\_

Location #

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
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|--|--|--|--|--|--|--|--|

**Note:** Eligibility under P.L. 2005, c.375, is limited to a subscriber's child under the age of 31; who is unmarried; has no dependent(s) of his/her own; is a resident of New Jersey or a full-time student at an accredited public or private institution of higher education; and 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. Coverage is limited to the SHBP or SEHBP medical and prescription drug plans that are identical to the plans in which the parent is enrolled. The covered parent is responsible for the entire cost of coverage. Proof of child's age and transcripts for students attending school outside of the State of New Jersey are required.

**2. COVERED PARENT'S INFORMATION** — Parent's name (*last, first*)

|                                   |                                     |                                |
|-----------------------------------|-------------------------------------|--------------------------------|
| <b>Gender</b>                     | <b>Birth Date</b><br>____/____/____ | <b>Social Security Number</b>  |
| <b>Telephone Number</b><br>(    ) |                                     | <b>Personal E-mail Address</b> |
| <b>Street Address</b>             |                                     |                                |
| <b>City</b>                       | <b>State</b>                        | <b>Zip</b>                     |

**3. BILLING ADDRESS** (*If different from child's address*)

|                       |              |            |
|-----------------------|--------------|------------|
| <b>Street Address</b> |              |            |
| <b>City</b>           | <b>State</b> | <b>Zip</b> |

**4. CHAPTER 375 COVERAGE ELECTION**

Under Chapter 375, an over age child does not have any choice in the selection of benefits but is enrolled for coverage in exactly the same plan or plans (medical and/or prescription drug) that the covered parent has selected. There is no provision for eligibility for dental or vision benefits.

I wish to be enrolled in the same plan as my parent under the provisions of P.L.2005, c.375.

Enter the Physician ID# if enrolling in a HMO 

|  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
|  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|

I wish to TERMINATE ALL COVERAGE under P.L. 2005, c.375.    Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**5. 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 hereby make application to extend group insurance coverage under the terms of P.L.2005, c.375. I authorize the NJDPB to bill me for the monthly premium payments and further agree to make payments in a timely fashion. I understand this coverage will terminate without notice if payment is not made on time. 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 child as the assignee may require. I agree to notify the Health Benefits Bureau if my covered child becomes covered under another group health plan or becomes entitled to Medicare after electing coverage under Chapter 375, or otherwise becomes ineligible for any reason (see Note above). **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.

\*See instruction page for detailed information

6. \_\_\_\_\_  
SHBP/SEHBP Covered Parent's Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date Completed

\_\_\_\_\_  
SHBP/SEHBP Covered Child's Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date Completed

**DO NOT SEND PAYMENT WITH APPLICATION — YOU WILL BE BILLED**

## SHBP & SEHBP

### Completing Chapter 375 Application for coverage of an OVERAGE child up to age 31

Under the provisions of Chapter 375, P.L. 2005, certain over age children may be eligible for coverage under the State Health Benefits Program (SHBP) or School Employees' Health Benefits Program (SEHBP) until age 31. This includes a subscriber's child by blood or law who: is under the age of 31 (a copy of the Birth Certificate is required); unmarried; has no dependent(s) of his or her own; is a resident of New Jersey or is a full-time student at an accredited public or private institution of higher education; and 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. An over age child is eligible for coverage in the SHBP or SEHBP medical and prescription drug plans that are identical to the plans in which the covered parent is enrolled. The covered parent is responsible for the entire cost of coverage (see Section 3 below for details).

#### SECTION 1 — COVERED CHILD'S INFORMATION

This section pertains to the child enrolling in the Chapter 375 coverage. Complete all requested information. Provide month, day, and year for Date of Birth (for example: April 12, 1980 = 04 12 80). If child is a full-time student, attach copy of the transcript from the accredited public or private institution of higher education. Please be certain to indicate the specific relationship to the covered parent (natural child, adopted, stepchild, etc.).

#### SECTION 2 — COVERED PARENT'S INFORMATION

This section pertains to the covered parent under whom regular SHBP or SEHBP dependent child coverage eligibility has ended. Complete all requested information. Provide month, day, and year for Date of Birth (for example: March 22, 1957 = 03 22 57). Please also include a home telephone number for the covered parent.

#### SECTION 3 — BILLING ADDRESS

List the complete mailing address where the Health Benefits Bureau should send the monthly bill for Chapter 375 premium payment. The covered parent is responsible for the entire cost of coverage. When Chapter 375 coverage is elected, the covered parent will be billed directly by the SHBP for the cost of the coverage. Chapter 375 rates for all SHBP and SEHBP plans are available over the Internet at: [www.state.nj.us/treasury/pensions/health-benefits.shtml](http://www.state.nj.us/treasury/pensions/health-benefits.shtml)

#### SECTION 4 — COVERAGE ELECTION

Check the appropriate box(es):

- Indicate that you wish to enroll for Chapter 375 coverage. You must indicate the same plan in which the covered parent is enrolled. If you select an HMO, you must also list the identification number of the child's Primary Care Physician. Prescription drug coverage, if provided through the SHBP or SEHBP, will be the same as the covered parent's prescription drug enrollment; or
- Indicate that you wish to terminate all coverage under Chapter 375.

#### SECTION 5 — CERTIFICATION AND SIGNATURE

Both the Chapter 375 covered child and the covered parent must read the certification and sign and date the application.

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

Return this application and all supporting documentation to:

**NJ DIVISION OF PENSIONS & BENEFITS  
HEALTH BENEFITS BUREAU  
P.O. BOX 299  
TRENTON, NJ 08625-0299**

## REQUIRED DOCUMENTATION FOR SHBP/SEHP DEPENDENT ELIGIBILITY AND ENROLLMENT

HB-0840-0717

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 DPB (Division of Pensions & 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 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   |
|--|---|--|
| <b>SPOUSE</b>                                  | A person to whom you are legally married.   | A copy of the marriage certificate <b>and</b> 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. <b>Or</b> , 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.  |
| <b>CIVIL UNION PARTNER</b>                     | A person of the same sex with whom you have entered into a civil union.   | A copy of the New Jersey civil union certificate or a valid certification from another jurisdiction that recognizes same-sex civil unions <b>and</b> a copy of the front page of the employee/retiree's NJ 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 Civil Union occurred in the current calendar year a copy of the tax return is not required. <b>Or</b> , 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.   |
| <b>DOMESTIC PARTNER</b>                        | 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 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 <b>and</b> a copy of the front page of the employee/retiree's NJ 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. <b>Or</b> , 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. |
| <b>CHILDREN</b>                                | A subscriber's child until age 26, <i>regardless</i> of the child's marital, student, or financial dependency status – even if the young adult no longer lives with his or her parents.<br><br>This includes a stepchild, foster child, legally adopted child, or any child in a guardian-ward relationship upon submitting required supporting documentation.  | <b>Natural or Adopted Child</b> – A copy of the child's birth certificate showing the name of the employee/retiree as a parent.<br><b>Step Child</b> – A copy of the child's birth certificate showing the name of the employee/retiree's spouse or partner as a parent <b>and</b> a copy of the marriage/partnership certificate showing the names of the employee/retiree and spouse/partner.<br><b>Legal Guardian, Grandchild, or Foster Child</b> – Copies of final court orders with the presiding judge's signature and seal. Documents must attest to the legal guardianship by the employee.   |
| <b>DEPENDENT CHILDREN WITH DISABILITIES</b>    | 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) <b>and</b> 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.  |
| <b>CONTINUED COVERAGE FOR OVERAGE CHILDREN</b> | Certain children over age 26 may be eligible for continued coverage until age 31 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" 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](http://www.vitalrec.com) or [www.studentclearinghouse.org](http://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](http://www.nj.gov/health/vital/index.shtml)