A:

# HEALTH BENEFITS PROGRAM APPLICATION — SEHBP EDUCATION ACTIVE EMPLOYEE GROUPS

Division of Pension and Benefits, P.O. Box 299, Trenton, NJ 08625-0299 HA-0890-0913

**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/SEHBP participating employer?

☐ No ☐ Yes If yes, list name of employer: _____

**2. MEDICAL COVERAGE**

**2a. EMPLOYEE SELECTION** (Choose only one plan)

| HORIZON | AETNA |
|---|---|
| ☐ NJ DIRECT15 | ☐ Aetna Freedom15 |
| ☐ NJ DIRECT10 | ☐ Aetna Freedom10 |
| ☐ NJ DIRECT1525 | ☐ Aetna Freedom1525 |
| ☐ NJ DIRECT2030 | ☐ Aetna Freedom2030 |
| ☐ NJ DIRECT2035 | ☐ Aetna Freedom2035 |
| ☐ Horizon HMO | ☐ Aetna HMO |
| ☐ Horizon HMO1525 | ☐ Aetna HMO1525 |
| ☐ Horizon HMO2030 | ☐ Aetna HMO2030 |
| ☐ Horizon HMO2035 | ☐ Aetna HMO2035 |

For HMO Plans, enter Primary Care Physician's ID# _____

☐ I elect to waive medical coverage in any medical plan (see instructions).*

**To sign up for a High Deductible Health Plan (HDHP), you must complete a *High Deductible Health Plan Application.* For more information, see your benefits administrator, or go to *www.state.nj.us/treasury/pensions***

**2b. LEVEL OF COVERAGE**

☐ Single ☐ Member and Spouse/Civil Union Partner

☐ Member and Domestic Partner (see instructions)

☐ Family ☐ Parent and Child(ren)

**3. PRESCRIPTION DRUG COVERAGE**

**3a. EMPLOYEE SELECTION**

☐ I wish to be covered by the Employee Prescription Drug Plan.

☐ I elect to waive Employee Prescription Drug Plan coverage.*

**3b. LEVEL OF COVERAGE**

☐ Single ☐ Member and Spouse/Civil Union Partner

☐ Member and Domestic Partner (see instructions)

☐ Family ☐ Parent and Child(ren)

**Note:** Education employers must have elected to provide the Employee Prescription Drug Plan to employees as a separate prescription drug benefit to be eligible for this coverage. If you are eligible for prescription drug coverage through another employer provided plan, or if your employer does not provide a separate drug plan, do not complete this selection. If your Education employer does not provide any separate drug coverage, your SHBP medical plan will include a prescription drug benefit.

*Both Medical **and** (if applicable) Prescription Drug coverage must be waived to avoid paying a contribution.

**DIVISION USE ONLY**

Effective Dates: Event Reason:

H _____ _____ _____

P _____ _____ _____

**EMPLOYER CERTIFICATION**

*See instructions on reverse*

Employer Name: _____

Location # (State Monthly and Local/Educational)

10/12 month employee (Enter "10" or "12")

**MEMBER ACTION**

☐ New Enrollment ☐ Transfer

Date Employment Began ____/____/____ (mm/dd/yy)

☐ Return from Leave of Absence ____/____/____ (mm/dd/yy)

_____

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).

| | Last Name | First Name | MI | Date of Birth (mm/dd/yy) | Gender (M/F) | Social Security Number | Dependent's HMO Primary Care Physician ID# | Natural (C) Adopted (A) Foster (F) Step (S) Legal Ward (L) See Instructions |
|---|---|---|---|---|---|---|---|---|
| ☐ Spouse/Civil Union/Domestic Partner | | | | | | | | |
| Children | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

**5. TYPE OF ACTIVITY**

(complete only if requesting changes to existing coverage)

**5a. ADDITION OF DEPENDENT**

☐ Marriage - Date of Event (mm/dd/yy) _____

(Copy of Marriage Certificate required)

Former Name _____

☐ Civil Union/Domestic Partner - Date of Event (mm/dd/yy) _____

(Copy of Certificate of Civil Union or Domestic Partnership required)

☐ Birth of Child ☐ Adoption/Guardianship - proof required

Date of Event (mm/dd/yy) _____

**5b. DELETION OF SPOUSE OR PARTNER**

☐ Divorce ☐ Dissolution of Civil Union ☐ Death

☐ Termination of Domestic Partnership

Date of Event (mm/dd/yy) _____

**5c. DELETION OF CHILD**

☐ Deletion of Child - Date of Event (mm/dd/yy) _____

Child's Name _____

Child's SSN _____

Give Reason _____

**5d. OTHER CHANGES**

☐ Change in last name only (Attach copy of supporting documentation)

(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) _____

**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 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 dependents as the assignee may require.

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

_____ _____

Employee Signature Date Completed