OPEN ENROLLMENT

HEALTH BENEFITS PROGRAM APPLICATION — SHBP STATE ACTIVE EMPLOYEE GROUP

Division of Pension and Benefits, P.O. Box 299, Trenton, NJ 08625-0299 HA-0891-0913

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 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)

*Both Medical and 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: _____

Payroll # (State Biweekly) | Union Code (Rx) Only

Location # (State Monthly)

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

OPEN ENROLLMENT

HD-0719-0914

NEW JERSEY EMPLOYEE DENTAL PLANS APPLICATION

Division of Pension 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

Are you transferring from another SHBP/SEHBP participating employer? ☐ Yes ☐ No

(Area Code) Home Telephone Number

If yes, name of employer:

2. DENTAL COVERAGE

2a. EMPLOYEE SELECTION (You must remain enrolled in the Dental Plan for a minimum of 12 months)

☐ I wish to be covered under the Dental Expense Plan. (Aetna DEP) ; or

I wish to be covered under a Dental Plan Organization (DPO).

☐ Aetna DPO ☐ Healthplex

☐ Cigna ☐ Horizon BCBSNJ

☐ MetLife

Name of Dentist or ID# _____

☐ I am changing dental plans only:

From _____

To _____

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

2b. LEVEL OF COVERAGE

☐ Single ☐ Member and Spouse/Civil Union Partner

☐ Member and Domestic Partner (see instructions)

☐ Family ☐ Parent and Child(ren)

DIVISION USE ONLY

Effective Dates: Event Reason:

D _____ _____ _____

EMPLOYER CERTIFICATION

See instructions on reverse

Employer Name: _____

Payroll # (State Biweekly) | Union Code (Rx) Only

Location # (State Monthly or 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 ____/____/____

Signature of Certifying Officer

Telephone # Date Mailed

3. 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	Name of Dependent's Dentist or ID#	Natural (C) Adopted (A) Foster (F) Step (S) Legal Ward (L) See Instructions
Spouse/Civil Union/Domestic Partner								
Children								

4. TYPE OF ACTIVITY

(complete only if requesting changes to existing coverage)

4a. ADDITION OF DEPENDENT

(attach required proof of dependency documentation)

☐ Marriage

Date of Event (mm/dd/yy) _____

(attach Marriage Certificate and supporting documents)

Former Name _____

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

(attach Certificate of Civil Union or Domestic Partnership and supporting documents)

☐ Birth of Child (attach supporting documents)

☐ Adoption/Guardianship - proof required

Date of Event (mm/dd/yy) _____

4b. DELETION OF SPOUSE OR PARTNER

☐ Divorce ☐ Dissolution of Civil Union

☐ Termination of Domestic Partnership ☐ Death

Date of Event (mm/dd/yy) _____

4c. DELETION OF CHILD

☐ Deletion of Child -

Date of Event (mm/dd/yy) _____

Child's Name _____

Child's SSN _____

Give Reason _____

4d. 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) _____

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 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 understand that I must remain enrolled in the Dental Plan for a minimum of 12 months and that there is no guarantee of continuous participation by dental service providers, either dentists or facilities in the DPO plans. If either my dentist or dental center terminates participation in my selected plan, I must select another dentist or dental center participating in that plan to receive the "in-network" benefit. I authorize any hospital, physician, dentist, or dental care provider to furnish my dental plan or its assignee with such dental 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 _____