HA-0910-0519

State Health Benefits Program (SHBP) • School Employees Health Benefits Program (SEHBP)

ACTIVE EMPLOYEE HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

HEALTH BENEFITS ENROLLMENT and/or CHANGE FORM

1. EMPLOYEE INFORMATION — Last Name | First | MI

Gender	Birth Date	Social Security Number	Marital Status*
	/ /	— —	

Telephone Number ( )

Personal Email Address

Home Address No. and Street Name

City | State | Zip

2. EMPLOYMENT STATUS ☐ Full Time ☐ Part Time ☐ Intermittent ☐ National Guard ☐ ACA *(monthly only)*

3. REASON FOR APPLICATION ***(check one)***

☐ New Enrollment ☐ Transfer

☐ Open Enrollment ☐ Loss of Coverage

☐ Adding Dependents ☐ Deleting Dependents

☐ Waiver of Coverage ☐ Other

Reason_____

Date of Event _____/_____/_____

4. LEVEL OF COVERAGE

Level

☐ Single

☐ Parent/Child

☐ Member/Spouse/Civil Union

☐ Member/Domestic Partner

☐ Family

DIVISION USE ONLY

Effective Dates Event Reason:

H ____ ____ ____ ☐

EMPLOYER CERTIFICATION

(See Instructions on reverse)

Employer Name _____

Payroll # _____

(State Biweekly)

Union Code *(Rx) Only* ☐☐

Location # ☐☐☐☐☐☐☐

10/12 - month employee ☐☐

(Enter "10 or 12")

MEMBER ACTION

☐ New Enrollment ☐ Transfer

Date Employment Began

_____/_____/_____

☐ Return from Leave of Absence

_____/_____/_____

_____

Signature of Certifying Officer

_____

Telephone # *Date Mailed*

☐ **I have been offered the above coverage and I elect to waive participation for myself and my eligible dependents. ***

5. HEALTH PLAN

HORIZON		AETNA	
☐ NJ DIRECT HD4000***	☐ NJ DIRECT HD1500**	☐ Aetna Value HD4000***	☐ Aetna Value HD1500**

6. HEALTH SAVINGS ACCOUNT (HSA)

☐ I wish to establish a HSA at this time and understand that I will be contacted to establish banking. By applying for and funding my HSA I represent that I:

1) am covered under a High Deductible Health Plan (HDHP);
2) am not covered by any other non-HDHP product;
3) am not covered in Medicare; and
4) cannot be claimed as a dependent on another person's tax return.

☐ I am not enrolling in a HSA at this time and understand that if I choose to at a later date, I must contact my health plan.

7. Dependent Information: List all eligible dependents and attach required proof of dependency documents*

☐ **Additional sheets attached. Any dependents not listed will be removed.**

Eligible Dependents Last Name, First Name	Social Security No.	Circle Relationship	Birth Date	Gender
	— —	Spouse / Civil Union / Domestic Partner	/ /	
	— —	Child (Natural, Adopted, Foster, Step, Legal Ward)	/ /	
	— —	Child (Natural, Adopted, Foster, Step, Legal Ward)	/ /	

***See Instructions page for detailed information and Mailing Address**

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 pursuant to N.J.S.A.17:33A-6c.

8. Employee Signature: _____ **Date:** _____/_____/_____

INSTRUCTIONS FOR THE SHBP & SEHBP ACTIVE EMPLOYEE HIGH DEDUCTIBLE HEALTH PLAN HEALTH BENEFITS ENROLLMENT and/or CHANGE FORM

SECTION 1 – EMPLOYEE INFORMATION – Complete entire section. Indicate Marital Status as follows: **S** (Single), **M** (Married), **CU** (Civil Union), **DP** (Domestic Partner), **D** (Divorced), **W** (Widowed)

SECTION 2 – EMPLOYMENT STATUS – Check one block only

SECTION 3 – REASON FOR APPLICATION – Check one block only

- **New Enrollment** – New hire or HIPAA event
- **Transfer** – Active health benefits coverage transferring from another SHBP/SEHBP location
- **Open Enrollment** – Annually in October
- **Adding Dependents** – Must be done within 60 days of event (i.e. birth, marriage, adoption – indicate reason and date)
- **Deleting Dependents** – Removal of covered dependents (indicate reason and date)
- **Loss of Coverage** – Enrolling because of loss of other coverage (application and HIPAA certificate submitted within 60 days of the loss of other coverage)
- **Waiver of Coverage** – Waive (decline) coverage
- **Other** (indicate reason and date)
- **Reason** – indicate reason
- **Date of Event** – indicate date

To waive (decline) coverage: If you wish to waive Health coverage under the provisions of N.J.S.A. 52:14-17.31a, check appropriate block. **Note:** Both Health and Prescription Drug coverage must be waived to avoid paying a contribution. If you are waiving coverage for yourself or any or all of your eligible dependents because of other group health coverage, you may enroll in the future. You must provide proof of the loss of other coverage and submit it with your application within 60 days of the loss of other coverage. Otherwise you will be required to wait until the annual Open Enrollment.

SECTION 4 – LEVEL OF COVERAGE – Indicate by checking the appropriate block to enroll in a High Deductible Health Plan (HDHP)

- **Single** – coverage for you only
- **Parent/Child(ren)** – coverage for you and any eligible child(ren) under age 26
- **Member/Spouse/Civil Union** – coverage for you and your eligible spouse or your Civil Union Partner
- **Member/Domestic Partner** – coverage for you and your eligible Domestic Partner
- **Family** – coverage for you, your eligible Spouse/Civil Union Partner/Domestic Partner, and child(ren) under age 26

SECTION 5 – HEALTH PLAN – Select only one plan. The *Health Benefits Summary Program Description* provides you with all available options. Employees who choose a HDHP cannot enroll in another prescription drug plan. Prescription drug benefits are provided through the health plan. Guidebooks can be found on our website at: ***www.nj.gov/treasury/pensions***

**Part-time employees cannot enroll in the NJ DIRECT HD1500 or Aetna Value HD1500 plans.

***SEHBP employees cannot enroll in the NJ DIRECT HD4000 or Aetna Value HD4000 plans.

SECTION 6 – HEALTH SAVINGS ACCOUNT (HSA) – A Health Savings Account (HSA) is only available to employees who enroll in a HDHP. Enrollment in a HSA is voluntary. To enroll, complete a separate Health Savings Account form, which can be found on our website at: ***www.nj.gov/treasury/pensions*** Your human resources representative can answer questions and/or assist you with the completion of the form.

SECTION 7 – DEPENDENT INFORMATION – List all eligible dependents and attach dependent documentation proof (see attached). 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. Ensure your dependents match your level of coverage (Section 4). Your child(ren) may be covered until the end of the calendar year they turn 26. Any dependents not listed will not be covered. Attach extra pages for additional dependents. **Note:** Use Section 3 to delete dependents.

SECTION 8 – EMPLOYEE SIGNATURE – Read, sign, date, and attach required dependent documentation. Return the application to your employer's Human Resources office for certification.

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.

EMPLOYER CERTIFICATION – Must be completed by the Certifying Officer. The Certifying Officer's signature confirms that:

- The employee is eligible;
- The application is legible and completed in its entirety;
- The employee's selected plans and coverage levels are appropriate;
- The dependent documentation provided is complete and correct;
- The Employer Certification section is completed in its entirety; and
- The information presented is true to the best of their knowledge.

MAIL COMPLETED APPLICATION TO: **New Jersey Division of Pensions & Benefits (NJDPB)**
Health Benefits Bureau
P.O. Box 299
Trenton, NJ 08625-02999

HB-0840-1217

State Health Benefits Program (SHBP) • School Employees' Health Benefits Program (SEHBP)

REQUIRED DOCUMENTATION FOR 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 eligible dependents are receiving health care coverage under the Programs. The New Jersey Division of Pensions & Benefits (NJDPB) 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
SPOUSE	A person to whom you are legally married.	A copy of the marriage certificate **and** 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. **Or**, 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 spouses and is received at the same address.
CIVIL UNION PARTNER	A person of the same sex with whom you have entered into a civil union.	A copy of the marriage certificate **and** a copy of the front page of the employee/retiree's federal tax return***** (Form 1040) from last year that includes the partner. If filing separately, submit a copy of both partners' tax returns that list the same address. If marriage occurred in the current calendar year, a copy of the tax return is not required. **Or**, 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.
DOMESTIC PARTNER	A person of the same sex with whom you have entered into a domestic partnership. Under P.L. 2003, c. 246, 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 **and** a copy of the front page of the employee/retiree's N.J. 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. **Or**, 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.
CHILDREN	A subscriber's child until age 26, regardless of the child's marital, student, or financial dependency status – even if the young adult no longer lives with his or her parents. This includes a stepchild, foster child, legally adopted child, or any child in a guardian-ward relationship upon submitting required supporting documentation.	**Natural or Adopted Child** – A copy of the child's birth certificate showing the name of the employee/retiree as a parent. **Step Child** – A copy of the child's birth certificate showing the name of the employee/retiree's spouse or partner as a parent **and** a copy of the marriage/partnership certificate showing the names of the employee/retiree and spouse/partner. **Legal Guardian, Grandchild, or Foster Child** – Copies of final court orders with the presiding judge's signature and seal. Documents must attest to the legal guardianship by the employee.
DEPENDENT CHILDREN WITH DISABILITIES	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) **and** 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.
CONTINUED COVERAGE FOR OVERAGE CHILDREN	Certain children over age 26 may be eligible for continued coverage until age 31 under the provisions of P.L. 2005, c. 375. 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*** or ***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***

State of New Jersey • Division of Pensions & Benefits (NJDPB)
State Health Benefits Program (SHBP) • School Employees' Health Benefits Program (SEHBP)

HEALTH SAVINGS ACCOUNT (HSA) CONTRIBUTION FORM

EMPLOYEE INFORMATION

Employee Name:_____
Last *First* *Middle Initial*

Social Security #:_____ Location #: _____ Date: _____/_____/_____

PAYROLL REQUEST

☐ I authorize my employer to deduct the Health Savings Account (HSA) contribution identified below on a pre-tax basis beginning no earlier than the date my HSA medical plan will become effective. The funds are eligible to be deposited into my Health Savings Account.

Contributions are subject to federal limits. Annual limits for 2019: $3,500 for individuals; $7,000 for families.

Note: Employer contributions to your HSA count toward the annual limit.

Additional allowable contributions for individuals between the ages of 55 - 65: $1,000 for the account holder only.

Please fill in the desired amount below.

Per Pay: _____

Contributions will begin after your HSA bank account has been opened with the banking institution selected by your provider.

☐ Cancel deductions for the Health Savings Account from my paycheck.

HEALTH PLAN

High Deductible Health Plan (HDHP) *(Choose one from below)*

☐ NJ DIRECT HD4000*
☐ NJ DIRECT HD1500
☐ Aetna Value HD4000*
☐ Aetna Value HD1500

*School Employees' Health Benefits Plan members are not eligible to select NJ DIRECT HD4000 or Aetna Value HD4000.

Coverage Level *(Choose one from below)*

☐ Single
☐ Family
☐ Parent and Child(ren)
☐ Member and Spouse/Civil Union Partner
☐ Member and Domestic Partner

Employee Signature:_____ **Date:** _____/_____/_____

Please return the completed form with your enrollment application to your benefits administrator

BENEFITS ADMINISTRATORS: RETAIN THIS FORM FOR YOUR FILES