HEALTH BENEFITS PROGRAM APPLICATION — SHBP STATE ACTIVE EMPLOYEE GROUP

Division of Pension and Benefits, P.O. Box 299, Trenton, NJ 08625-0299 HA-0891-1011

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	CIGNA
☐ NJ DIRECT15	☐ Aetna HMO	☐ CIGNA HMO
☐ NJ DIRECT1525	☐ Aetna1525	☐ CIGNA1525
☐ NJ DIRECT2030	☐ Aetna2030	☐ CIGNA2030
☐ NJ DIRECT HD4000	☐ Aetna HD4000	☐ CIGNA HD4000
☐ NJ DIRECT HD1500	☐ Aetna HD1500	☐ CIGNA HD1500

For Aetna or CIGNA Plans, enter Primary Care Physician's ID# _____

☐ I elect to waive medical coverage in any medical 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)

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)

Employees who choose a high deductible (HD) health plan cannot enroll in another prescription drug plan. Prescription drug benefits will be provided in conjunction with the medical plan. **Do not complete this section if you chose a high deductible (HD) health plan.**

*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 NJ DIRECT and HMO 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