

RETIRED COVERAGE ENROLLMENT APPLICATION
State Health Benefits Program - School Employees' Health Benefits Program
New Jersey Division of Pensions and Benefits
P.O. Box 299 • Trenton, NJ 08625-0299

1. APPLICANT INFORMATION

Form fields for applicant information including Social Security Number, Last Name, First Name, Middle Name, Street Address, PO Box, City, State, Zip Code, Date of Birth, Gender, Area Code, Home Telephone Number, Date of Retirement, and Status (Single, Married, Civil Union, Divorced, Widowed, Domestic Partnership).

Were you a part time employee when you retired?
Yes No

Former Employer
Table with columns YES, NO and rows for Medicare Part A, Medicare Part B, and Spouse/Partner Medicare Part A/B. Includes instruction: 'If your child has Medicare, list child's name and Social Security Number and attach a copy of the Medicare card.'

2. TYPE OF ACTIVITY -- Submit this application if you are a new enrollee for SHBP or SEHBP Retired Group coverage. Check one box in Section 2A; then complete Sections 3 and 4 to select Medical/Dental Coverage. If you are already enrolled and wish to change coverage, add or delete dependents, or cancel coverage, please submit the Retired Change of Status Application.

2A. ENROLLMENT ACTION REQUESTED
New Retiree
Survivor Enrollment: Decedent's SS#

3A. MEDICAL COVERAGE (Check one box only).

Form for medical coverage selection with columns for HORIZON, AETNA, and CIGNA. Options include NJ DIRECT15, NJ DIRECT10, NJ DIRECT 1525, NJ DIRECT2030, NJ DIRECT HD4000*, Aetna HMO, CIGNA HMO, Aetna 1525, Aetna2030*, CIGNA 1525, AetnaHD2030, Aetna HD4000*, CIGNA HD4000*.

* Medicare eligible retirees and dependents cannot enroll in High Deductible (HD) plans or Aetna 2030.

For Aetna or CIGNA Plans, Enter Primary Care Physician's ID#:

Form for medical coverage selection with options: I do not wish to be covered, I wish to waive coverage, I have coverage with another employer, I have coverage with spouse/partner's employer, and Other (Give Reason).

3B. LEVEL OF COVERAGE (Check one box)

Form for level of coverage selection with options: Single, Member & Spouse/Civil Union Partner, Parent/Child, Member & Domestic Partner.

4A. DENTAL COVERAGE (Check one box only)

Form for dental coverage selection with options: I wish to be covered by the Retiree Dental Expense Plan, I do not wish to be covered, I wish to waive coverage, I have coverage with another employer, I have coverage with spouse/partner's employer. Includes field for List Employer.

4B. LEVEL OF COVERAGE (Check one box)

Form for level of dental coverage selection with options: Single, Member & Spouse/Civil Union Partner, Family, Parent/Child, Member & Domestic Partner.

4C. PREVIOUS DENTAL COVERAGE

Form for previous dental coverage with questions: Were you enrolled in a group dental plan for at least 12 months prior to retirement? If yes, please provide: Dental Plan Name, Telephone Number, Your Dental Plan ID Number.

5. DEPENDENT INFORMATION -- List eligible dependents to include for coverage and attach required proof of dependency documents (see instructions on reverse). Attach another sheet of paper for three or more dependents.

Table for dependent information with columns: Spouse/Partner, Children, Last Name, First Name, MI, Date of Birth, Gender, Social Security Number, and Dependent's HMO Primary Care Physician ID#.

FOR DIVISION USE ONLY
Event Reason, Effective Date, Waiver Code, Location No.
Waiver Codes: 3 - (voluntary) 4 - (non-response) 5 - (spouse) 6 - (employer)

6. I certify that all the information supplied on this form is true to the best of my knowledge. I authorize a pension deduction from my pension check, including initial check, last check benefit, withdrawal check, or return of contributions check as required by the State Health Benefits Commission or School Employees' Health Benefits Commission. I also understand that there is no guarantee of continuous participation by medical service providers, either doctors or facilities in the NJ DIRECT or HMO plans. I authorize any hospital, physician, dentist, or health or dental care provider to furnish my medical/dental plan or its assignee with such medical/dental information about myself, or my covered dependents on this application, as the assignee may require. I further authorize my current dental plan, if applicable, to release information deemed necessary for enrollment in this plan. Anyone eligible for Medicare (age 65 or older or in receipt of Social Security Disability benefits) must be enrolled under both Hospital Insurance (Part A) and Medical Insurance (Part B) in order to continue coverage under this program. PROOF OF ENROLLMENT IS REQUIRED. If I or a covered dependent enroll in Medicare at a later date, I understand that the Health Benefits Bureau must be notified immediately.
Applicant's Signature Date:
Additional Sheet Attached Medicare Proof Enclosed