

1. COVERED CHILD'S 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 #) **Note:** If a full-time student outside of New Jersey, attach copy of transcript.

City State ZIP Code + 4 -

Date of Birth (mm/dd/yy) Gender (M/F) (Area Code) Home Telephone Number - -

Marital Status (Check One)
 - Single - Married / Civil Union / Domestic Partnership - Divorced / Widowed

Relationship to Employee/Retiree (Check One)
 - Natural Child - Adopted - Stepchild - Other (explain) _____

DIVISION USE ONLY

Effective Dates:

H _____

P _____

Location #

Note: Eligibility under Chapter 375, P.L. 2005, is limited to a subscriber's child under the age of 31; who is unmarried; has no dependent(s) of his/her own; is a resident of New Jersey or a full-time student at an accredited public or private institution of higher education; and 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. Coverage is limited to the SHBP or SEHBP medical and prescription drug plans that are identical to the plans in which the parent is enrolled. The covered parent is responsible for the entire cost of coverage.

Proof of child's age and transcripts for students attending school outside of the State of New Jersey are required.

2. COVERED PARENT'S INFORMATION

Social Security Number - -

Last Name

First Name

Date of Birth (mm/dd/yy)

(Area Code) Home Telephone Number -

3. BILLING ADDRESS - If different from child's address

Street Address (Include Apartment #)

City

State ZIP Code + 4 -

4. CHAPTER 375 COVERAGE ELECTION

Indicate your selection with an **X** in the appropriate box — coverage must be the same as that of the subscriber parent. *Must include Physician ID# if selecting an HMO.*

- I wish to be enrolled in **NJ DIRECT15**
- I wish to be enrolled in **NJ DIRECT10**
- I wish to be enrolled in **Aetna HMO** - Enter Aetna Physician ID#
- I wish to be enrolled in **CIGNA HealthCare HMO** - Enter CIGNA Physician ID#
- I wish to **TERMINATE ALL COVERAGE** under Chapter 375, P.L. 2005

5. I CERTIFY that all the information supplied on this form is true to the best of my knowledge. I hereby make application to extend group insurance coverage under the terms Chapter 375, P.L. 2005. I authorize the Division of Pensions and Benefits to bill me for monthly premium payments and further agree to make further payments in a timely fashion. I understand this coverage will terminate without notice if payment is not made on time. I also understand that there is no guarantee of continuous participation by medical service providers, either doctors, hospitals, or other facilities in NJ DIRECT in-network coverage or the HMO plans. If my physician or medical center terminates participation in my selected plan, I must elect another doctor or medical center participating in that plan to receive the NJ DIRECT in-network or HMO 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 child as the assignee may require. I agree to notify the Health Benefits Bureau if my covered child becomes covered under another group health plan or become entitled to Medicare after electing coverage under Chapter 375, or otherwise becomes ineligible for any other reason (see Note above).

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

SHBP/SEHBP Covered Parent's Signature Date Completed

Covered Child's Signature Date Completed

**COMPLETING THE CHAPTER 375 APPLICATION
FOR COVERAGE OF OVER AGE CHILD UP TO AGE 31
STATE HEALTH BENEFITS PROGRAM
SCHOOL EMPLOYEES' HEALTH BENEFITS PROGRAM**

Under the provisions of Chapter 375, P.L. 2005, certain over age children may be eligible for coverage under the State Health Benefits Program (SHBP) or School Employees' Health Benefits Program (SEHBP) until age 31. This includes a subscriber's child by blood or law who: is under the age of 31 (a copy of the Birth Certificate is required); unmarried; has no dependent(s) of his or her own; is a resident of New Jersey or is a full-time student at an accredited public or private institution of higher education; and 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. An over age child is eligible for coverage in the SHBP or SEHBP medical and prescription drug plans that are identical to the plans in which the covered parent is enrolled. The covered parent is responsible for the entire cost of coverage (see Section 3 below for details).

SECTION 1 — COVERED CHILD'S INFORMATION

This section pertains to the child enrolling in the Chapter 375 coverage. Complete all requested information, filling in one letter or number per block. Provide month, day, and year for Date of Birth (for example: April 12, 1980 = 04 12 80). If child is a full-time student, attach copy of the transcript from the accredited public or private institution of higher education. Please be certain to indicate the specific relationship to the covered parent (natural child, adopted, stepchild, etc.).

SECTION 2 — COVERED PARENT'S INFORMATION

This section pertains to the covered parent under whom regular SHBP or SEHBP dependent child coverage eligibility has ended. Complete all requested information, filling in one letter or number per block. Provide month, day, and year for Date of Birth (for example: March 22, 1957 = 03 22 57). Please also include a home telephone number for the covered parent.

SECTION 3 — BILLING ADDRESS

List the complete mailing address where the Health Benefits Bureau should send the monthly bill for Chapter 375 premium payment. The covered parent is responsible for the entire cost of coverage. When Chapter 375 coverage is elected, the covered parent will be billed directly by the SHBP for the cost of the coverage. Chapter 375 rates for all SHBP and SEHBP plans are available over the Internet at: www.state.nj.us/treasury/pensions/shbp.htm

SECTION 4 — COVERAGE ELECTION

Check the appropriate box(es):

- Indicate that you wish to enroll for Chapter 375 coverage. You must indicate the same plan in which the covered parent is enrolled. If you select an HMO you must also list the identification number of the child's Primary Care Physician. Prescription drug coverage, if provided through the SHBP or SEHBP, will be the same as the covered parent's prescription drug enrollment; or
- Indicate that you wish to terminate all coverage under Chapter 375.

SECTION 5 — CERTIFICATION AND SIGNATURE

Both the Chapter 375 covered child and the covered parent must read the certification and sign and date the application.

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

Return this application and all supporting documentation to:

**NJ DIVISION OF PENSIONS AND BENEFITS
HEALTH BENEFITS BUREAU
P.O. BOX 299
TRENTON, NJ 08625-0299**