HA-0780-0418

State Health Benefits Program (SHBP)

STATE ACTIVE EMPLOYEE GROUP

EMPLOYEE COVERAGE WAIVER/REINSTATEMENT FORM

PART 1: EMPLOYEE INFORMATION — Last Name | First | MI

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

Telephone Number: ( )

Personal E-mail Address:

Home Address No. and Street Name:

City | State | Zip

EMPLOYMENT STATUS ☐ Full Time ☐ National Guard

Check one box below.

DIVISION USE ONLY

Effective Dates: H ____ ____ ____ Rx ____ ____ ____

Event Reason: ☐

EMPLOYER CERTIFICATION

(See Instructions on reverse)

Employer Name _____

Location # (State Monthly) ☐☐☐☐☐☐☐

10/12 - month employee ☐☐ *(Enter "10 or 12")*

MEMBER ACTION

☐ New Enrollment ☐ Existing

Date Employment Began

_____/_____/_____

Signature of Certifying Officer

Telephone # *Date Mailed*

☐ **Waiver of Coverage**

I agree to voluntarily waive State Health Benefits Program (SHBP) coverage to which I am entitled because I am covered under other health coverage. I understand that while coverage is waived, I will not be required to make payroll contributions required for medical and/or prescription drug coverage.

I understand that I may resume SHBP coverage if I lose coverage under the other health coverage, provided that I notify the SHBP within 60 days of the loss of the other coverage and provide proof of loss of that coverage.

I wish to waive *(check one)* ☐ Medical Coverage ☐ Prescription Coverage ☐ Both

☐ **Reinstatement of Coverage**

I previously waived SHBP coverage because I had other health coverage. As of _____/_____/_____, I am no longer covered by the other health plan, request reinstatement of the SHBP coverage, and have provided proof of loss of the other coverage. I further understand that coverage is permitted as an employee, retiree, or dependent; however, multiple coverage under the State Health Benefits Program is prohibited. A *Health Benefits Enrollment and/or Change* Form, along with proof of loss of other coverage, is required for all reinstatements.

Employee's Signature _____ **Date** _____/_____/_____

PART 2: To be completed by the employer. Check one box below.

☐ We understand that this employee is requesting to voluntarily waive SHBP coverage.

☐ We request reinstatement of this employee's SHBP coverage.

A reinstatement must be filed within 60 days of the loss of other health coverage. If this timetable is followed, the coverage will be retroactive to the date of loss. If the 60 day time limit has passed, the employee must wait until the next open enrollment period to reenroll.

MAIL COMPLETED APPLICATION TO:

New Jersey Division of Pensions & Benefits
Health Benefits Bureau
P.O. Box 299
Trenton, NJ 08625-0299