



School Employees' Health Benefits Program (SEHBP)
EDUCATION ACTIVE EMPLOYEE GROUP
HEALTH BENEFITS ENROLLMENT and/or CHANGE FORM

1. EMPLOYEE INFORMATION — Last Name				First	MI	DIVISION USE ONLY																					
Gender	Birth Date	Social Security Number	Marital Status*			Effective Dates	Event Reason:																				
	/ /	— —				H _____	<input type="checkbox"/>																				
Telephone Number		Personal E-mail Address				Rx _____																					
()		Home Address No. and Street Name				EMPLOYER CERTIFICATION <i>(See instructions on reverse)</i>																					
City		State		Zip		Employer Name _____																					
						Location # (State Monthly) <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25px;"> </td> <td style="width:25px;"> </td> <td style="width:25px;"> </td> <td style="width:25px;"> </td> </tr> </table>																					
						10/12 - month employee <i>(Enter "10" or "12")</i> <input type="checkbox"/>																					
2. EMPLOYMENT STATUS <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> National Guard				3. REASON FOR APPLICATION (check one)				MEMBER ACTION																			
<input type="checkbox"/> New Enrollment <input type="checkbox"/> Transfer <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Adding Dependents <input type="checkbox"/> Deleting Dependents <input type="checkbox"/> Waiver of Coverage <input type="checkbox"/> Other Reason _____ Date of Event ____/____/____				4. TYPE and LEVEL OF COVERAGE <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Level</th> <th style="text-align: center;">Health</th> <th style="text-align: center;">Rx*</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Single</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Parent/Child</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Member/Spouse/Civil Union</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Member/Domestic Partner</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Family</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>				Level	Health	Rx*	<input type="checkbox"/> Single	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Parent/Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Member/Spouse/Civil Union	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Member/Domestic Partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> New Enrollment <input type="checkbox"/> Transfer Date Employment Began ____/____/____ <input type="checkbox"/> Return from Leave of Absence ____/____/____ _____ <i>Signature of Certifying Officer</i> _____ Telephone # _____ Date Mailed _____	
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<input type="checkbox"/> Family	<input type="checkbox"/>	<input type="checkbox"/>																									

I have been offered the above coverage and I elect to waive participation for myself and my eligible dependents.* *(Note: Oral contraceptive coverage is available under the medical plan.)* I elect to waive Health Coverage I elect to waive Prescription Drug Coverage

5. HEALTH PLAN

HORIZON <input type="checkbox"/> NJ DIRECT10 <input type="checkbox"/> NJ DIRECT15 <input type="checkbox"/> NJ DIRECT1525 <input type="checkbox"/> NJ DIRECT2030 <input type="checkbox"/> NJ DIRECT2035	<input type="checkbox"/> Horizon HMO <input type="checkbox"/> Horizon HMO1525 <input type="checkbox"/> Horizon HMO2030 <input type="checkbox"/> Horizon HMO2035	AETNA <input type="checkbox"/> Aetna Freedom10 <input type="checkbox"/> Aetna Freedom15 <input type="checkbox"/> Aetna Freedom1525 <input type="checkbox"/> Aetna Freedom2030 <input type="checkbox"/> Aetna Freedom2035 <input type="checkbox"/> Aetna HMO <input type="checkbox"/> Aetna HMO1525 <input type="checkbox"/> Aetna HMO2030 <input type="checkbox"/> Aetna HMO2035
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For HMO Plans only, enter Primary Care Physician's ID # _____

6. 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.

7. Employee Signature: _____ **Date:** ____/____/____



**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