HEALTH BENEFITS PROGRAM APPLICATION — SHBP STATE	ACTIVE EMPLOYEE GROUP Division of P	Pension and Benefits, P.O. Box 299, Trenton, NJ 08625-0299	HA-0891-1012	DIVISION USE ONLY
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 (mrm/dd/yy) Gender (M/F)  Status:  -Single  -Married  -Civil  Partnership  -Divorced  -Widower  (Area Code)  Home Telephone Number  Are you transferring your health benefits from another SHBP/SEHBP participating employer?	2. MEDICAL COVERAGE  2a. EMPLOYEE SELECTION (Choose only one plan HORIZON AETNA  NJ DIRECT15 Aetna Freedom155  NJ DIRECT1525 Aetna Freedom2030  Horizon HMO Aetna HMO Horizon HMO1525 Aetna HMO1525  Horizon HMO2030 Aetna HMO2030  For HMO Plans, enter Primary Care Physician's ID#  I elect to waive medical coverage in any medical p (see instructions).*  To sign up for a High Deductible Health Plan (Health Pla	3. PRESCRIPTION DRUG COVERAGE  3a. EMPLOYEE SELECTION  I wish to be covered by the Employee Prescription Drug F  3b. LEVEL OF COVERAGE  Single Member and Spouse/Civil UMember and Domestic Partner (see instruction Family Parent and Child(ren)  IDHP), you must be see your beneary/pensions	otion Drug Plan. lan coverage.* nion Partner	Effective Dates: Event Reason:  H
□ No □ Yes If yes, list name of employer:		ption Drug coverage must be waived to avoid paying a contribution.		Telephone # Date Mailed
4. DEPENDENT INFORMATION - List only eligible dependents and attach required proof of	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
(complete only if requesting changes to existing coverage)  5a. ADDITION OF DEPENDENT  ☐ Marriage - Date of Event (mm/dd/yy)		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)	form is true to the bes I waive my right to coo scheduled open enroll (HIPAA). I also unders medical providers, eith medical center term another doctor or m "in-network" benefit. I furnish my medical pla or my covered depend Misrepresentation:	FICATION - I certify that all the information supplied on this to finy knowledge and that it is verifiable. I understand that if verage at this time, enrollment is not permissible until the next ment or if other coverage is lost and proof of loss is provided tand that there is no guarantee of continuous participation by ner doctors or facilities in the plans. If either my physician or inside participation in my selected plan, I must select nedical center participating in that plan to receive the authorize any hospital, physician, or health care provider to in or its assignee with such medical information about myself lents as the assignee may require. Any person that knowingly provides false or misleading to criminal and civil penalties.

## REQUIRED DOCUMENTATION FOR SHBP/SEHBP 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, eligible children, and eligible dependents are receiving health care coverage under the programs. As a result, the Division of Pensions and Benefits must guarantee consistent application of eligibility requirements within the plans. Employees or Retirees who enroll children or dependents for coverage (spouses, civil union partners, domestic partners, children, disabled and/or over age children continuing coverage) must submit the following documentation in addition to the appropriate health benefits enrollment or change of status application.

DEPENDENTS	ELIGIBILITY DEFINITION	DOCUMENTATION REQUIRED	
SPOUSE	A person of the opposite sex to whom you are legally married.	A photocopy of the <i>Marriage Certificate</i> <b>and</b> a photocopy of the front page of the employee/retiree's most recently filed federal tax return* ( <i>Form 1040</i> ) that includes the spouse.	
CIVIL UNION PARTNER	A person of the same sex with whom you have entered into a civil union.	A photocopy of the <i>New Jersey Civil Union Certificate</i> or a valid certification from another jurisdiction that recognizes same-sex civil unions <b>and</b> a photocopy of the front page of the employee/retiree's most recently filed New Jersey tax return* that includes the partner <b>or</b> a photocopy of a recent (within 90 days of application) bank statement or bill 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 Chapter 246, P.L. 2003, 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 photocopy of the <i>New Jersey Certificate of Domestic Partnership</i> dated prior to February 19, 2007 or a valid certification from another State of foreign jurisdiction that recognizes same-sex domestic partners <b>and</b> a photocopy of the front page of the employee/ retiree's most recently filed New Jersey tax return* that includes the partner <b>or</b> a photocopy of a recent (within 90 days of application) bank statement or bill 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 guardianward relationship upon submitting required supporting documentation.	Natural or Adopted Child – A photocopy of the child's birth certificate showing the name of the employee/retiree as a parent.  Step Child – A photocopy of the child's birth certificate showing the name of the employee/retiree's spouse or partner as a parent and a photocopy of the marriage/partnership certificate showing the names of the employee/retiree and spouse/partner.  Legal Guardian, Grandchild, or Foster Child – Photocopies of Final Court Orders with the presiding judge's signature and seal. Documents must attest to the legal guardianship by the covered 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, and (2) the child continues to be disabled, and (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) <b>and</b> a photocopy of the front page of the employee/retiree's most recently filed federal tax return* ( <i>Form 1040</i> ) 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. <b>Please note</b> 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 OVER AGE CHILDREN	Certain children over age 26 may be eligible for continued coverage until age 31 under the provisions of Chapter 375, P.L. 2005. 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) <b>and</b> a photocopy of the front page of the child's most recently filed federal tax return* ( <i>Form 1040</i> ), <b>and</b> if the child resides outside of the State of New Jersey, documentation of full time student status must be submitted.	

\*Note: For tax forms you may black out all financial information and all but the last 4 digits of any Social Security numbers.

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 Web sites: www.vitalrec.com or www.studentclearinghouse.org
Residents of New Jersey can obtain records from the State Bureau of Vital Statistics and Registration Web site: www.state.nj.us/health/vital/index.shtml