TCNJ
THE COLLEGE OF NEW JERSEY

## ***Office of Human Resources***

## ***Emergency Information***

*(please type or print all information)*

**PLEASE COMPLETE THIS FORM IN ITS ENTIRETY**

☐ NEW HIRE ☐ CHANGE (circle one) *Name/Address/Phone/Emergency Contact*

Date_____

Name (*print*)_____ EmpID_____
*Last* *First* *M.I.*

Street Address_____ City_____

County_____ State_____ Zip Code_____ Home Phone_____

Department_____ Supervisor_____

Campus Building_____ Room Number_____ Campus Phone_____

## **Emergency Contacts:**

1. Name _____ Relationship_____

   Street Address_____ City_____ State____Zip Code_____

   Home Phone (  )_____ Work Phone(  )_____Cell Phone(  )_____

2. Name_____ Relationship_____

   Street Address_____ City_____ State____Zip Code_____

   Home Phone (  )_____ Work Phone(  )_____ Cell Phone(  )_____

FC-0162-0310

STATE OF NEW JERSEY
DEPARTMENT OF THE TREASURY

## DIVISION OF PENSIONS AND BENEFITS

PO Box 295, Trenton, NJ 08625-0295

# CHANGE OF ADDRESS FORM

**Please print all required information** and return the completed form to the mailing address shown above. This form will be rejected if your retirement/membership number and/or your Social Security number is not completed.

Date: _____

Name: _____

Pension System: ☐ PERS ☐ TPAF ☐ DCRP ☐ PFRS ☐ SPRS ☐ ABP ☐ JRS

Membership or Retirement Number: _____

Social Security Number: _____ — _____ — _____

Daytime Phone Number: (_____) _____
AREA CODE

Type of Change: ☐ Active Employee Address Change for Health Benefits
Note: The Division does not maintain addresses for active employee pension accounts. Notify your employer of any change in your address.

☐ Retiree Address Change for Pension and Health Benefits

Former Mailing Address: _____
ADDRESS

_____
ADDRESS 2

_____
CITY STATE ZIP

Date New Address in Effect: _____
MONTH DAY YEAR

New Mailing Address: _____
ADDRESS

_____
ADDRESS 2

_____
CITY STATE ZIP

_____
Signature of Member or Retiree

NJDPB Pensions & Benefits
Explore Your Benefits

HA-0891-0617

# SHBP STATE ACTIVE EMPLOYEE GROUP
## HEALTH BENEFITS ENROLLMENT *and/or* CHANGE FORM

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

**1. EMPLOYEE INFORMATION — Employee Name** ***(last, first)***

| Gender | Birth Date | Social Security Number | Marital Status* |
|---|---|---|---|
| | _____/_____/_____ | – – | |

| Telephone Number | Personal E-mail Address |
|---|---|
| ( ) | |

Street Address

City | State | Zip

**2. EMPLOYMENT STATUS**

☐ Full Time ☐ Part Time ☐ Intermittent ☐ National Guard ☐ ACA *(monthly only)*

**3. REASON FOR APPLICATION** ***(check one)***

☐ New Enrollment ☐ Transfer
☐ Open Enrollment ☐ Loss of Coverage
☐ Adding Dependents ☐ Deleting Dependents
☐ Waiver of Coverage ☐ Other

Reason_____
Date of Event _____/_____/_____

**4. TYPE and LEVEL of COVERAGE**

| Level | Health | Rx |
|---|---|---|
| ☐ Single | ☐ | ☐ |
| ☐ Parent/Child(ren) | ☐ | ☐ |
| ☐ Member/Spouse/Civil Union | ☐ | ☐ |
| ☐ Member/Domestic Partner | ☐ | ☐ |
| ☐ Family | ☐ | ☐ |

**DIVISION USE ONLY**

Effective Dates Event Reason:
H _____ _____ _____
Rx _____ _____ _____

**EMPLOYER CERTIFICATION**
*See instructions on reverse*

Employer Name: _____
Payroll # _____ Union Code*(Rx) Only*
(*State Biweekly*)
Location # *(State Monthly)*
10/12-month employee *(Enter "10" or "12").*

**MEMBER ACTION**

☐ New Enrollment ☐ Transfer

Date Employment Began _____/_____/_____ *(mm/dd/yy)*

☐ Return from Leave of Absence _____/_____/_____ *(mm/dd/yy)*

*Signature of Certifying Officer*

*Telephone #* *Date Mailed*

**I have been offered the above coverage and I elect to waive participation for myself and my eligible dependents.***

I elect to waive ☐ Health Coverage I elect to waive ☐ Prescription Drug Coverage

**5. HEALTH PLAN**

| HORIZON | | AETNA | |
|---|---|---|---|
| ☐ OMNIA Health Plan | ☐ NJ DIRECT2030 | ☐ Aetna Liberty Plan | ☐ Aetna Freedom2030 |
| ☐ NJ DIRECT15 | ☐ NJ DIRECT2035 | ☐ Aetna Freedom15 | ☐ Aetna Freedom2035 |
| ☐ NJ DIRECT1525 | ☐ Horizon HMO | ☐ Aetna Freedom1525 | ☐ Aetna HMO |

**6. Dependent Information:** List all eligible dependents and attach required proof of dependency documents.*
**Any dependents not listed will be removed.**

| Eligible Dependents Last Name, First Name | Social Security No. | Circle Relationship | Birth Date *mm/dd/yyyy* | Gender |
|---|---|---|---|---|
| | – – | Spouse/Civil Union Domestic Partner | / / | |
| | – – | Child *(Natural, Adopted, Foster, Step, Legal Ward)* | / / | |
| | – – | Child *(Natural, Adopted, Foster, Step, Legal Ward)* | / / | |
| | – – | Child *(Natural, Adopted, Foster, Step, Legal Ward)* | / / | |

**** See Instructions page for detailed information***

**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:** _____/_____/_____

# INSTRUCTIONS FOR THE SHBP STATE ACTIVE EMPLOYEE GROUP HEALTH BENEFITS ENROLLMENT and/or CHANGE FORM

**SECTION 1 – EMPLOYEE INFORMATION** – Complete entire section. Indicate **Marital Status** as follows: **S** (Single), **M** (Married), **C** (Civil Union), **DP** (Domestic Partner), **D** (Divorced), **W** (Widowed)

**SECTION 2 – EMPLOYMENT STATUS** – Check one block only

**SECTION 3 – REASON FOR APPLICATION** – Check one block only

- **New Enrollment** – New hire or HIPAA event
- **Transfer** – Active health benefits coverage transferring from another SHBP/SEHBP location
- **Open Enrollment** – Annually in October
- **Adding Dependents** – Must be done within 60 days of event (i.e. birth, marriage, adoption – indicate reason and date)
- **Deleting Dependents** – Removal of covered dependents (indicate reason and date)
- **Loss of Coverage** – Enrolling because of loss of other coverage (application and HIPAA certificate submitted within 60 days of the loss of other coverage)
- **Waiver of Coverage** – Waive (decline) coverage
- **Other** (indicate reason and date)
- **Reason** – indicate reason
- **Date of Event** – indicate date

To waive (decline) coverage: If you wish to waive Health and/or Prescription Drug coverage under the provisions of N.J.S.A. 52:14-17.31a, check appropriate block. **NOTE: Both Health AND Prescription Drug coverage MUST be waived to avoid paying a contribution.** If you are waiving coverage for yourself or any or all of your eligible dependents because of other group health coverage, you may enroll in the future. You must provide proof of the loss of other coverage and submit it with your application within 60 days of the loss of other coverage. Otherwise you will be required to wait until the annual Open Enrollment.

**SECTION 4 – TYPE AND LEVEL OF COVERAGE** – Indicate by checking the appropriate block to enroll in **Health** and/or **Rx** (Prescription Drug)

- **Single** – coverage for you only
- **Parent/Child(ren)** – coverage for you and any eligible child(ren) under age 26
- **Member/Spouse/Civil Union** – coverage for you and your eligible spouse or your Civil Union Partner
- **Member/Domestic Partner** – coverage for you and your eligible Domestic Partner
- **Family** – coverage for you, your eligible Spouse/Civil Union Partner/Domestic Partner, and child(ren) under age 26

**SECTION 5 – HEALTH PLAN** – Select only one plan. The Health Benefits *Summary Program Description* provides you with all available options at ***www.state.nj.us/treasury/pensions/handbooks.shtml*** Employees who wish to enroll in a High Deductible Health Plan (HDHP) must use the appropriate application found on our website ***www.nj.gov/treasury/pensions***

**SECTION 6 – DEPENDENT INFORMATION** – List all eligible dependents and attach dependent documentation proof (see attached). 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. Ensure your dependents match your level of coverage (Section 4). Your child(ren) may be covered until the end of the calendar year they turn 26. **ANY DEPENDENTS NOT LISTED WILL NOT BE COVERED.**

**NOTE:** Use Section 3 to delete dependents.

**SECTION 7 – EMPLOYEE SIGNATURE** – Read, sign, date, and attach required dependent documentation. Return the application to your employer's Human Resources office for certification.

**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.

**EMPLOYER CERTIFICATION** – Must be completed by the Certifying Officer. The Certifying Officer's signature confirms that:

- The employee is eligible
- The application is legible and completed in its entirety
- The employee's selected plans and coverage levels are appropriate
- The dependent documentation provided is complete and correct
- The Employer Certification section is completed in its entirety and
- The information presented is true to the best of their knowledge

# REQUIRED DOCUMENTATION FOR SHBP/SEHBP DEPENDENT ELIGIBILITY AND ENROLLMENT

HB-0840-0717

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 DPB (Division of Pensions & Benefits) 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 partners 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 New Jersey civil union certificate or a valid certification from another jurisdiction that recognizes same-sex civil unions **and** a copy of the front page of the employee/retiree's NJ 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 Civil Union 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 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 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 NJ 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.<br>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.<br>**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.<br>**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 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), 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***

NJDPB Pensions & Benefits
Explore Your Benefits

# NEW JERSEY EMPLOYEE DENTAL PLANS
## ENROLLMENT *and/or* CHANGE FORM

HD-0719-0717
Division of Pensions & Benefits
P.O. Box 299
Trenton, NJ 08625-0299

**1. EMPLOYEE INFORMATION — Employee Name** ***(last, first)***

| Gender | Birth Date | Social Security Number | Marital Status* |
|---|---|---|---|
| | _____/_____/_____ | – – | |

| Telephone Number | Personal E-mail Address |
|---|---|
| ( ) | |

Street Address

City | State | Zip

**DIVISION USE ONLY**

Effective Dates: Event Reason:
D _____ _____ _____

**EMPLOYER CERTIFICATION**
*See instructions on reverse*

Employer Name: _____

Payroll # (State Biweekly) ☐☐☐☐

Union Code (Rx) Only ☐☐

Location # (State Monthly or Local/Education) ☐☐☐☐-☐☐

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

**MEMBER ACTION**

☐ New Enrollment ☐ Transfer

Date Employment Began
_____/_____/_____ (mm/dd/yy)

☐ Return from Leave of Absence
_____/_____/_____ (mm/dd/yy)

_____
Signature of Certifying Officer

_____/_____/_____ (mm/dd/yy)

Telephone #_____

**2. REASON FOR APPLICATION** ***(check one)***

☐ New Enrollment ☐ Transfer
☐ Open Enrollment ☐ Loss of Coverage
☐ Adding Dependents ☐ Deleting Dependents
☐ Waiver of Coverage ☐ Other

Reason_____

Date of Event _____/_____/_____

**3. LEVEL OF COVERAGE**

☐ Single
☐ Parent/Child(ren)
☐ Member/Spouse/Civil Union
☐ Member/Domestic Partner
☐ Family

☐ I have been offered the above dental coverage and **I elect to waive participation** for myself and my eligible dependents.*

**4. DENTAL PLAN** You must remain enrolled in selected plan for 12 months.

I wish to be covered under a Dental Plan Organization (DPO)*

☐ Aetna DMO ☐ Cigna ☐ MetLife ☐ Healthplex ☐ Horizon BCBSNJ

☐ I wish to be covered under the Dental Expense Plan (Aetna DEP)*

**5. Dependent Information:** List all eligible dependents and attach required proof of dependency documents.*
**Any dependents not listed will be removed.**

| Eligible Dependents Last Name, First Name | Social Security No. | Circle Relationship | Birth Date *mm/dd/yyyy* | Gender |
|---|---|---|---|---|
| | – – | Spouse/Civil Union Domestic Partner | / / | |
| | – – | Child *(Natural, Adopted, Foster, Step, Legal Ward)* | / / | |
| | – – | Child *(Natural, Adopted, Foster, Step, Legal Ward)* | / / | |
| | – – | Child *(Natural, Adopted, Foster, Step, Legal Ward)* | / / | |

**** See Instructions page for detailed information***

**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 understand that I must remain enrolled in the Dental Plan for a minimum of 12 months and that there is no guarantee of continuous participation by dental service providers, either dentists or facilities, in the DPO plans. If either my dentist or dental center terminates participation in my selected plan, I must select another dentist or dental center participating in that plan to receive the "in-network" benefit. I authorize any hospital, physician, dentist or dental care provider to furnish my dental plan or its assignee with such dental 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.

**6. Employee Signature:**_____ **Date:** _____/_____/_____

# INSTRUCTIONS FOR THE NEW JERSEY EMPLOYEE DENTAL PLANS ENROLLMENT and/or CHANGE FORM

**SECTION 1 – EMPLOYEE INFORMATION** – Complete entire section. Indicate **Marital Status** as follows: **S** (Single), **M** (Married), **C** (Civil Union), **DP** (Domestic Partner), **D** (Divorced), **W** (Widowed)

**SECTION 2 – REASON FOR APPLICATION** – Check one block only

- **New Enrollment** – New hire or HIPAA event
- **Transfer** – Active dental benefits coverage transferring from another SHBP/SEHBP location
- **Open Enrollment** – Annually in October
- **Adding Dependents** – Must be done within 60 days of event (i.e. birth, marriage, adoption – indicate reason and date)
- **Deleting Dependents** – Removal of covered dependents (indicate reason and date)
- **Loss of Coverage** – Enrolling because of loss of other coverage (application and HIPAA certificate submitted within 60 days of the loss of other coverage)
- **Waiver of Coverage** – Waive (decline) coverage
- **Other** (indicate reason and date)
- **Reason** – indicate reason
- **Date of Event** – indicate date

To waive (decline) coverage: If you wish to waive Dental coverage under the provisions of N.J.S.A. 52:14-17.31a, check appropriate block. If you are waiving coverage for yourself or any or all of your eligible dependents because of other group health coverage, you may enroll in the future. You must provide proof of the loss of other coverage and submit it with your application within 60 days of the loss of other coverage. Otherwise you will be required to wait until the annual Open Enrollment.

**SECTION 3 – LEVEL OF COVERAGE** – Indicate by checking the appropriate block

- **Single** – coverage for you only
- **Parent/Child(ren)** – coverage for you and any eligible child(ren) under age 26
- **Member/Spouse/Civil Union** – coverage for you and your spouse or your Civil Union Partner
- **Member/Domestic Partner** – coverage for you and your Domestic Partner
- **Family** – coverage for you, your eligible Spouse/Civil Union Partner/Domestic Partner, and child(ren) under age 26

**SECTION 4 – DENTAL PLAN** – Select only one plan. The *Employee Dental Plans Member Handbook* provides you with all available options at ***www.state.nj.us/treasury/pensions/handbooks.shtml*** If you enroll in a **Dental Plan Organization (DPO)** you must receive services from an in-network dentist in order to have your claims paid. You must select a participating dentist within the DPO, ensuring the dentist or facility takes new patients and participates with the Employee Dental Plans. If you enroll in the **Dental Expense Plan (Aetna DEP)** you may receive services from any dentist. You will be required to pay up-front for covered services until a deductible is met.

**IMPORTANT: After you enroll in a Dental Plan you must remain enrolled for 12 months until you are permitted to terminate coverage.**

**SECTION 5 – DEPENDENT INFORMATION** – List all eligible dependents and attach dependent documentation proof (see attached). 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. Ensure your dependents match your level of coverage (Section 4). Your child(ren) may be covered until the end of the calendar year they turn 26. **ANY DEPENDENTS NOT LISTED WILL NOT BE COVERED.**

**Note:** Use Section 2 to delete dependents

**SECTION 6 – EMPLOYEE SIGNATURE** – Read, sign, date, and attach required dependent documentation. Return the application to your employer's Human Resources office for certification.

**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.

**EMPLOYER CERTIFICATION** – Must be completed by the Certifying Officer. The Certifying Officer's signature confirms that:

- The employee is eligible;
- The application is legible and completed in its entirety;
- The employee's selected plans and coverage levels are appropriate;
- The dependent documentation provided is complete and correct;
- The Employer Certification section is completed in its entirety; and
- The information presented is true to the best of their knowledge.

# REQUIRED DOCUMENTATION FOR SHBP/SEHBP DEPENDENT ELIGIBILITY AND ENROLLMENT

HB-0840-0717

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 DPB (Division of Pensions & Benefits) 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 partners 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 New Jersey civil union certificate or a valid certification from another jurisdiction that recognizes same-sex civil unions **and** a copy of the front page of the employee/retiree's NJ 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 Civil Union 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 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 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 NJ 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.<br>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.<br>**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.<br>**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 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), 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***