HC-1010-1020

State Health Benefits Program (SHBP) • School Employees' Health Benefits Program (SEHBP)

Local Government and Local Education Employees and Retirees

COBRA APPLICATION

1. MEMBER INFORMATION — Last Name | First | MI

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

Phone Number ( )

Email Address

Street Address | City | State | Zip

DIVISION USE ONLY

Effective Dates

H _____/_____/_____

P _____/_____/_____

D _____/_____/_____

V _____/_____/_____

Event Reason

Location #

Term (mos)

2. CHANGE OF INFORMATION — TYPE

☐ **Status Change** (Indicate Reason Below) ☐ **Open Enrollment** ☐ **Other** _____

- Moved Out of Coverage Area (Date of Move) _____/_____/_____
- Add Spouse (Attach Marriage Certificate and Give Date of Event) _____/_____/_____
- Add Civil Union/Domestic Partner (Attach Civil Union or Domestic Partnership Certificate and Give Date of Event) _____/_____/_____
- Add Dependent Child (Date of Event) _____/_____/_____ Adoption/Guardianship (Date of Event) _____/_____/_____ (Proof Required)

3. LEVEL AND TYPE OF COVERAGE

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

4. DENTAL PLAN INFORMATION (Check one)

☐ Dental Expense Plan

☐ Dental Plan Organization (DPO)

Enter Name of DPO _____

Enter DPO Provider ID# _____

5. HEALTH PLAN — Check one box only

EDUCATION MEMBERS

☐ New Jersey Educators Health Plan
☐ NJ DIRECT15†
☐ NJ DIRECT10*†

Note: Retired Education members may only select the New Jersey Educators Health Plan

LOCAL GOVERNMENT MEMBERS

☐ NJ DIRECT/NJ DIRECT 2019†
☐ NJ DIRECT15
☐ NJ DIRECT10
☐ NJ DIRECT1525
☐ NJ DIRECT2030
☐ NJ DIRECT2035**
☐ Horizon HMO
☐ Horizon OMNIA
☐ NJ DIRECT HD1500
☐ NJ DIRECT HD4000

†*See Instructions page for more information.* **Non-State Employee Members Only.* ***2035 Plans not available to Retired Group Members*

For HD Plans only — Health Savings Account (HSA)

☐ I wish to establish an HSA at this time and understand that I will be contacted to establish banking. By applying for and funding your HSA you represent that you:

1) are covered under a High Deductible Health Plan
2) are not enrolled in Medicare
3) are not covered by any other non-HDHP product
4) cannot be claimed as a dependent on another person's tax return

To enroll in the Health Savings Account (HSA), complete the attached HSA contribution form to authorize deductions.

☐ I am not enrolling in an HSA at this time and understand that if I choose to at a later date, I must contact my carrier.

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**

MEMBER CERTIFICATION – I certify that all the information supplied on this form is true to the best of my knowledge. I hereby make application to extend my group insurance coverage under the terms of the program. I understand that my COBRA coverage will be continuous from the date benefits end. I authorize the Division of Pensions & Benefits to bill me for monthly premium payments and agree to make said payments in a timely fashion or COBRA coverage will terminate without notice. I understand that if I waive my right to coverage at this time, enrollment is not normally permissible at a later date. I also understand that there is no guarantee of continuous participation by medical or dental service providers, either doctors, dentists, or facilities. If my physician, dentist, or medical/dental center terminates participation in my selected plan, I must elect another doctor/dentist or medical/dental center participating in that plan to receive the in-network benefit. I authorize any hospital, physician, dentist, or health or dental care provider to furnish my medical or dental plan or its assignee with such medical or dental information about myself or my covered dependents as the assignee may require. I agree to notify the COBRA Administrator if I or any of my covered dependents become covered under another group health or dental plan or become entitled to Medicare after I elect coverage under COBRA. **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. Member Signature_____ **Date** _____/_____/_____

DO NOT SEND PAYMENT WITH APPLICATION - YOU WILL BE BILLED

INSTRUCTIONS FOR THE SHBP/SEHBP COBRA APPLICATION

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

SECTION 2 – CHANGE OF INFORMATION – Check one box only

- **Status Change** (Indicate reason)
  Moved Out of Coverage Area – (Date of Move)
  Add Spouse – (Attach Marriage Certificate and Give Date of Event)
  Add Civil Union/Domestic Partner – (Attach Marriage Certificate and Give Date of Event)
  Add Dependent Child/Birth/Adoption/Guardianship (Date of Event) (Proof Required)
- **Open Enrollment** – Annually in October
- **Other** (Specify)

SECTION 3 – LEVEL AND TYPE OF COVERAGE – Check the appropriate box to enroll in Health, Rx (Prescription Drug), Dental, and/or Vision (State only).

- **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 4 – DENTAL PLAN INFORMATION – Check one box only. Enter Name of DPO and DPO Provider ID# if applicable.

SECTION 5 – HEALTH PLAN – Select only one plan. The Health Benefits *Summary Program Description*, available on our website at: ***www.nj.gov/treasury/pensions***, provides you with all available options. Members who wish to enroll in a High Deductible Health Plan (HDHP) must complete a *Health Savings Account (HSA) Form.* Charts, applications, and forms can be found on our website at ***www.nj.gov/treasury/pensions*** †Education members who wish to enroll in NJ DIRECT10 or NJ DIRECT15 must have been hired prior to July 1, 2020. CWA Members hired before 7/1/2019, will be enrolled in CWA Unity DIRECT, and if hired after 7/1/2019, will be enrolled in CWA Unity DIRECT 2019. Other State and local members hired before 7/1/2019, will be enrolled in NJ DIRECT, and if hired after 7/1/2019, will be enrolled in NJ DIRECT 2019.

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. 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 7 – MEMBER SIGNATURE – Read, sign, and date application.

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.

MAIL COMPLETED APPLICATION TO:

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

HB-0840-0920

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.
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.
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 both partners' N.J. tax return***** from last year that includes the partner.
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 Ward, 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***