HC-0806-1012

— COBRA NOTICE —

CONTINUATION OF HEALTH BENEFITS COVERAGE UNDER COBRA

STATE HEALTH BENEFITS PROGRAM AND SCHOOL EMPLOYEES' HEALTH BENEFITS PROGRAM

This page is to be completed by Employer — *Please print or type.*

To the Family of —

_____

_____

_____

_____

SS#: _____

Notice Date: _____

Employer Name: _____

Emp ID #: _____

EMPLOYEE TYPE:

☐ 10 month

☐ 12 month

Dear Employee and/or Dependent(s):

Your health care coverage under the State Health Benefits Program (SHBP) or School Employees' Health Benefits Program (SEHBP) terminates as shown below because of a change in employment status or dependent eligibility. The reason for the loss of coverage, the type(s) of coverage lost and the last day of coverage(s) are shown in the notice below. Under the provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you are entitled to continue your medical benefits with the group program for a limited time.

If you wish to continue coverage under the provisions of COBRA, you must enroll at this time. Otherwise, you will lose coverage and you cannot enroll later.

You may continue the group coverage(s) shown below under COBRA, at your own expense, for the time period shown in the COBRA Continuation Term or until one of the following conditions occur: (1) you voluntarily cancel your coverage; (2) you become covered under MEDICARE or another group plan after you elect COBRA coverage (Note: Exceptions are made if your other group has a pre-existing condition clause that affects you); (3) you fail to pay your premiums in a timely manner; or (4) your employer ends participation in the SHBP or SEHBP.

In considering whether to elect continuation of coverage under COBRA, you should take into account that you cannot enroll at a later date and that a failure to continue your group health coverage may affect your future rights under federal law. Please refer to Fact Sheet #30, *Continuation of Coverage Under COBRA,* for more information on your election of COBRA coverage.

If you wish to continue your group coverage under the provisions of COBRA, complete the application on the reverse side and send it to the **Division of Pensions and Benefits, P.O. Box 299, Trenton, NJ, 08625-0299**. If you elect to continue coverage, you will be enrolled so you have no break in coverage. After your application is processed (allow up to three weeks), you will be sent a letter of confirmation of enrollment indicating the beginning date(s) of your COBRA coverage(s) and the length of your COBRA eligibility. The Health Benefits Bureau will send you an invoice of premiums that are due for your coverage (this may include retroactive premiums).

You should make a copy of this notice and your completed application for your records prior to mailing the application **and** any required proof of dependency documentation to the Division of Pensions and Benefits. After mailing, if you do not receive the confirmation of enrollment identified in the preceding paragraph, you should contact the Division of Pensions and Benefits' Office of Client Services at (609) 292-7524 or by e-mail at *pensions.nj@treas.state.nj.us*

COBRA EVENT: (check one)

- ☐ Termination: Involuntary
- ☐ Termination: Gross Misconduct
- ☐ Termination: Voluntary, Other
- ☐ Reduction in Hours
- ☐ Leave of Absence
  - — State/Federal Family Leave
  - — Other
- ☐ Death
- ☐ Divorce or Separation/Dissolution of Civil Union or Domestic Partnership
- ☐ Dependent Ineligibility Over Age 26
- ☐ Medicare Entitlement

CURRENT COVERAGE TYPE: (check one)

Medical Plan: _____ (Indicate Plan Name)	Dental*	Rx	Vision (State Only)
☐ Single (S)	☐ S	☐ S	☐ S
☐ Member & Spouse/Civil Union Partner (M&S/CU)	☐ M&S/CU	☐ M&S/CU	☐ M&S/CU
☐ Member & Domestic Partner (M&DP)	☐ M&DP	☐ M&DP	☐ M&DP
☐ Parent & Child(ren) (P&C)	☐ P&C	☐ P&C	☐ P&C
☐ Family (F)	☐ F	☐ F	☐ F

* Indicate Dental Plan

☐ Dental Expense Plan

☐ Name of Dental Plan Organization _____

DATE OF COBRA EVENT: _____

CONTINUATION TERM: _____ months of COBRA eligibility.

LAST DATE OF COVERAGE (Month/Date/Year): Medical _____ Dental _____ Rx _____ Vision _____

EMPLOYER CONTACT AND TELEPHONE #:_____

The Certifying Officer must sign here after printing the completed form.

_____

Signature of Certifying Officer

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE OR THE LAST DATE OF COVERAGE, WHICHEVER IS LATER, TO ELECT COVERAGE UNDER COBRA. FAILURE TO RESPOND WITHIN THIS TIME PERIOD IS CONSIDERED A DECISION NOT TO CONTINUE COVERAGE.

HEALTH BENEFITS PROGRAM COBRA APPLICATION - SHBP/SEHBP EMPLOYEE GROUP

HC-0806-1012

1. APPLICANT INFORMATION-This section must be filled out completely. Please print or type.

Applicant's Social Security Number ___ - __ - ____ Last Name _____ Title (Jr., Sr., etc.) ___

First Name _____ MI ___

Street Address (Include Apartment #) _____

City _____ State __ ZIP Code + 4 _____ - ____

Date of Birth (mm/dd/yy) ____ Gender (M/F) ___ (Area Code) ___ - ___ - ____ Home Telephone Number

Status (Check One): ☐ - Single ☐ - Married ☐ - Civil Union ☐ - Domestic Partnership ☐ - Divorced ☐ -Widowed

Relationship to Employee: ☐ - Self ☐ - Spouse/Partner ☐ - Child ☐ - Other _____

Employee's Social Security Number (if different than Applicant's): ___ - __ - ____

2. CHANGE INFORMATION (if applicable)

Type ☐ Open Enrollment

☐ Status Change (Indicate reason below)

Moved Out of Coverage Area (Date of Move) _____

Add Spouse (Date of Event) _____
(Attach Marriage Certificate)

Add Civil Union/Domestic Partner (Date of Event) _____
(Attach Civil Union or Domestic Partnership Certificate)

Add Dependent Child ☐ Birth ☐ Adoption/Guardianship (Proof Required)

(Date of Event) _____

Other (Specify) _____

DIVISION USE ONLY

Effective Dates: Event Reason:

H _____ _____ _____

P _____ _____ _____

D _____ _____ _____

V _____ _____ _____

Location # ____ Term (mos) ___

Spouse is a person of the opposite sex to whom you are legally married. A photocopy of the *Marriage Certificate* and most recent federal tax return that includes the spouse are required for enrollment (see requirements page).

Civil Union Partner is a person of the same sex with whom you have entered into a civil union. A photocopy of the *Civil Union Certificate* and most recent NJ tax return that includes the partner are required for enrollment (see requirements page).

Domestic Partner is a same-sex domestic partner, as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act. A photocopy of the *Certificate of Domestic Partnership* and most recent NJ tax return that includes the partner are required for enrollment. A local government/education employer must elect to provide domestic partner health benefits coverage (see requirements page).

To be eligible for the **Employee Prescription Drug Plan** or the **Employee Dental Plans** a local government/education employer must have elected to provide them as separate benefits. If you are eligible for prescription drug coverage through another employer provided plan, or if your employer does not provide any drug coverage, your SHBP/SEHBP medical plan will include a prescription drug benefit. If you are eligible for dental coverage through another employer provided plan, do not complete that part of the application.

3A. MEDICAL COVERAGE (Check one box only).

HORIZON	AETNA
☐ NJ DIRECT15	☐ Aetna Freedom15
☐ NJ DIRECT10	☐ Aetna Freedom10
☐ NJ DIRECT1525	☐ Aetna Freedom1525
☐ NJ DIRECT2030	☐ Aetna Freedom2030
☐ Horizon HMO	☐ Aetna HMO
☐ Horizon HMO1525	☐ Aetna HMO1525
☐ Horizon HMO2030	☐ Aetna HMO2030

For HMO Plans only, Enter Primary Care Physician's ID#: _____

3B. LEVEL OF COVERAGE (Check one box)

☐ Single (S)

☐ Member & Spouse/Civil Union Partner (M&S/CU) *(See Instructions)*

☐ Member & Domestic Partner (M&DP) *(See Instructions)*

☐ Parent/Child(ren) (P&C)

☐ Family (F)

4. INDICATE COVERAGE ELECTION: (check one)

Dental*	Rx	Vision (State Only)
☐ S	☐ S	☐ S
☐ M&S/CU	☐ M&S/CU	☐ M&S/CU
☐ M&DP	☐ M&DP	☐ M&DP
☐ P&C	☐ P&C	☐ P&C
☐ F	☐ F	☐ F

5. PROVIDER INFORMATION

*Indicate Dental Plan (check one):

☐ Dental Expense Plan

☐ Dental Plan Organization (DPO)

Enter Name of DPO _____

Name and Address of DPO Dental Provider

_____

_____

_____

6. DEPENDENT INFORMATION - List all eligible dependents you wish to enroll for coverage and attach required proof of dependency documents (see requirements page). Use a separate page for additional dependents.

☐ Spouse/Partner - Last Name	First Name	MI	Date of Birth (mm/dd/yy)	Gender (M/F)	Social Security Number	Dependent's HMO Primary Care Physician ID#	Name of Dependent's Dentist or DPO ID#	Natural (C) Adopted (A) Foster (F) Step (S) Legal Ward (L) See Instructions
Children								

7. ☐ **SSA DISABILITY EXTENSION** — Check this box if you have an approved Social Security Administration Disability and wish your COBRA term extended to up to 29 months. Attach a copy of the Social Security Administration Disability approval letter.

8. 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 coverage under COBRA will be continuous from the date benefits end. I authorize the Division of Pensions and Benefits to bill me for monthly premium payments and further agree to make further payments in a timely fashion. I understand this COBRA coverage will terminate without notice if payment is not made on time. 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 in the NJ DIRECT in-network, HMO, or DPO plans. 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.

_____ Applicant's Signature _____ Date Completed

DO NOT SEND PAYMENT WITH APPLICATION — YOU WILL BE BILLED

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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 *Marriage Certificate* **and** a photocopy of the front page of the employee/retiree's most recently filed federal tax return* (*Form 1040*) 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 *New Jersey Civil Union Certificate* or a valid certification from another jurisdiction that recognizes same-sex civil unions **and** a photocopy of the front page of the employee/retiree's most recently filed New Jersey tax return* that includes the partner **or** 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 *New Jersey Certificate of Domestic Partnership* dated prior to February 19, 2007 or a valid certification from another State of foreign jurisdiction that recognizes same-sex domestic partners **and** a photocopy of the front page of the employee/ retiree's most recently filed New Jersey tax return* that includes the partner **or** 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 guardian-ward 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) **and** a photocopy of the front page of the employee/retiree's most recently filed federal tax return* (*Form 1040*) 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 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) **and** a photocopy of the front page of the child's most recently filed federal tax return* (*Form 1040*), **and** 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***