

**CONTINUATION OF STATE HEALTH BENEFITS COVERAGE UNDER COBRA  
STATE HEALTH BENEFITS PROGRAM AND SCHOOL EMPLOYEES' HEALTH BENEFITS PROGRAM**

**ASSISTANCE ELIGIBILITY WAIVER FORM**

Use this form to notify your plan that you are eligible for other group health plan coverage or Medicare and therefore not eligible for reduced COBRA premiums under the American Recovery and Reinvestment Act of 2009 (ARRA). If you choose to do so, send the completed *Assistance Eligibility Waiver* form to:

**The Division of Pensions and Benefits  
PO Box 299  
Trenton, NJ 08625-0299**

You may also want to read the important information about your rights included in the "Summary of the COBRA Premium Reduction Provisions Under ARRA."

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**PERSONAL INFORMATION**

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Employee Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Employee Address: \_\_\_\_\_

E-mail address (optional): \_\_\_\_\_

Name of Former Employer: \_\_\_\_\_

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**COBRA INELIGIBILITY INFORMATION - INDIVIDUAL HAS OTHER COVERAGE**

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I am eligible for coverage under another group health plan.  Insert date you became eligible \_\_\_\_\_

List any dependents who are also eligible. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I am eligible for Medicare.  Insert date you became eligible \_\_\_\_\_

**To the best of my knowledge and belief, all of the answers I have provided on this form are true and correct.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Type or print name: \_\_\_\_\_