

NJ STATE HEALTH BENEFITS RETIRED STATUS APPLICATION
New Jersey Division of Pensions and Benefits
P.O. Box 299 • Trenton, NJ 08625-0299
Fax (609) 341-3407

HR-0075-0507

1. APPLICANT INFORMATION

Social Security Number - -

Were you a part time employee when you retired?
 Yes No

Last Name Title (Jr., Sr., etc.)

First Name Middle Name

Street Address Apartment #

PO Box City State

Zip Code + 4 - Date of Birth (mm/dd/yy) Gender (M/F)

Status (check one) Single Married Civil Union (see instructions)
 Divorced Widowed Domestic Partnership (see instructions)

Former Employer

Area Code - Home Telephone Number - Date of Retirement (mm/dd/yy)

	YES	NO
Do YOU have Medicare Part A? (Hospital Insurance)	<input type="checkbox"/>	<input type="checkbox"/>
Do YOU have Medicare Part B? (Medical Insurance)	<input type="checkbox"/>	<input type="checkbox"/>
Does YOUR SPOUSE/PARTNER have Medicare Part A?	<input type="checkbox"/>	<input type="checkbox"/>
Does YOUR SPOUSE/PARTNER have Medicare Part B?	<input type="checkbox"/>	<input type="checkbox"/>

Anyone eligible for Medicare (age 65 or older or in receipt of Social Security Disability benefits) must be enrolled under both Hospital Insurance (Part A) and Medical Insurance (Part B) in order to continue coverage under this program. If enrolled, a photocopy of the Medicare card must be submitted with this application.

If your child has Medicare, list child's name and Social Security # and attach a copy of the Medicare card.

2. TYPE OF ACTIVITY — Check one box in Section A; if you select **New Retiree, Survivor Enrollment, or Cancel Coverage**, skip to Part 3 and 4 Medical/Dental Coverage. If you select **Coverage Change**, complete Section B; if you select **Other Change**, complete Section C.

A. ENROLLMENT ACTION REQUESTED

New Retiree Survivor Enrollment: Decedent's SS#

Cancel Coverage Coverage Change Other Change

B. COVERAGE CHANGES

Medical Plan Change — From	To	Month	Day	Year
Marriage — Attach Marriage Certificate (Give Date of Event)				
Former Name <input type="text"/>				
Civil Union or Domestic Partnership — Attach Certificate of Civil Union or Certificate of Domestic Partnership (Give Date of Event)				
Birth of Child (Give Date of Event)				
Adoption/Guardianship — Proof Required (Give Date of Event)				
Deletion of Dependent (Give Date of Event)				
Dependent's name: <input type="text"/>	SS# <input type="text"/>			
Reason for Deletion:	<input type="checkbox"/> Death of Spouse/Partner <input type="checkbox"/> Divorce			
	<input type="checkbox"/> Dissolution of Civil Union or Domestic Partnership <input type="checkbox"/> Other <input type="text"/>			

C. OTHER CHANGES

Spouse/Partner's Health Benefits terminated with employer - Attach letter from employer

Change in last name only (Give Former Name)

Correction to Social Security # — Attach copy of Social Security Card (Give Former Social Security #)

Change in Birth Date (Give Name and Correct Date) — Attach copy of Birth Certificate

Addition of dependent's Social Security # (List the dependent(s) in Section 5)

Other: Give Reason (i.e., address change, dependent returns from military service, etc.)

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

I wish to be covered under **NJ PLUS**
 Enter Your NJ PLUS Primary Care Physician's ID #

I wish to be covered under an **HMO**. Name of HMO and #
 Enter Your HMO Primary Care Physician's ID #

I wish to be covered under the **Traditional Plan**

I **do not wish to be covered** under any of the medical plans (See instructions)

I wish to **waive coverage** under the medical plans for the following reason: (See instructions)
 I have coverage with another employer I have coverage with spouse/partner's employer
 List Employer

Other (Give Reason)

3B. LEVEL OF COVERAGE (Check one box)

Single Member & Spouse/Civil Union Partner (See Instructions)

Family Parent/Child(ren) Member & Domestic Partner (See Instructions)

4A. DENTAL COVERAGE

I wish to be covered by the **Retiree Dental Expense Plan**

I **do not wish to be covered** under the dental plan (See instructions)

I wish to **waive coverage** under the dental plan for the following reason: (See instructions)
 I have coverage with another employer I have coverage with spouse/partner's employer
 List Employer

4B. LEVEL OF COVERAGE (Check one box)

Single Member & Spouse/Civil Union Partner (See Instructions)

Family Parent/Child(ren) Member & Domestic Partner (See Instructions)

4C. PREVIOUS DENTAL COVERAGE

Are you currently enrolled in a group dental plan (for at least 12 months) Yes No

If yes, please provide the following information: Dental Plan Name

Dental Plan Telephone Number

Your Member ID#

5. DEPENDENT INFORMATION — List eligible dependents you wish to include on your coverage. If necessary, attach another sheet of paper.

<input type="checkbox"/> Spouse/Civil Union/Domestic Partner	Last Name	First Name	MI	Date of Birth (mm/dd/yy)	Gender (M/F)	Social Security Number	Dependent's NJ PLUS or HMO Primary Care Physician ID#	Natural (C) Adopted (A) Foster (F) Step (S) Legal Ward (L) See Instructions
<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

FOR DIVISION USE ONLY

Event Reason Effective Date

Location No.

6. I certify that all the information supplied on this form is true to the best of my knowledge. I authorize a pension deduction from my pension check — including initial check, last check benefit, withdrawal check, or return of contributions check — as required by the State Health Benefits Commission. I also understand that there is no guarantee of continuous participation by medical service providers, either doctors or facilities in the NJ PLUS or HMO plans. I authorize any hospital, physician, dentist, or health or dental care provider to furnish my medical/dental plan or its assignee with such medical/dental information about myself, or my covered dependents on this application, as the assignee may require. I further authorize my current dental plan, if applicable, to release information deemed necessary for enrollment in this plan. **Anyone eligible for Medicare (age 65 or older or in receipt of Social Security Disability benefits) must be enrolled under both Hospital Insurance (Part A) and Medical Insurance (Part B) in order to continue coverage under this program. PROOF OF ENROLLMENT IS REQUIRED.** If I or a covered dependent enroll in Medicare at a later date, I understand that the State Health Benefits Program must be notified immediately.

Applicant's Signature Date:

Additional Sheet Attached Medicare Proof Enclosed

COMPLETING THE STATE HEALTH BENEFITS PROGRAM RETIRED STATUS APPLICATION

SECTION 1 — APPLICANT INFORMATION

This section pertains to the person enrolling in the retired group. Complete all requested information, filling in one letter or number per block. Provide month, day, and year for Date of Birth and Date of Retirement (for example: April 12, 1933 = 04 12 33). Please indicate if you were a part-time employee.

SECTION 2 — TYPE OF ACTIVITY

Check one box in section A. If you have applied for retirement or are a new retiree, check the first box "New Retiree".

If you are enrolling in the State Health Benefits Program as a Surviving Spouse/Civil Union Partner/Domestic Partner/Dependent, check "Survivor Enrollment."

State Health Benefits Program coverage can be voluntarily cancelled at any time by checking "Cancel Coverage." However, if you voluntarily cancel your coverage, reinstatement into the State Health Benefits Program is not normally permissible.

For plan changes or to add or delete a dependent, check "Coverage Change" and enter the change information in section B.

For other changes check "Other Change" enter the change information in section C.

SECTION 3 — MEDICAL PLAN SELECTION

Check only one box indicating either: **1.)** The medical plan into which you want to enroll; or **2.)** That you do not want medical plan coverage (See "Declining or Waiving Coverage" below); or **3.)** That you want to waive medical plan coverage. (See "Declining or Waiving Coverage" below)

When choosing NJ PLUS or an HMO you must list the identification number (ID #) of your Primary Care Physician.

DECLINING OR WAIVING COVERAGE — If you are declining coverage and do not want State Health Benefits Program coverage, check the box indicating that you do not wish to be covered under any of the medical/dental plans.

If you requesting to waive enrollment for yourself and any of your eligible dependents because of other group health or dental insurance coverage from a public or private employer, check the box indicating that wish to waive coverage, indicate if the coverage is through your employment or that of your spouse/civil union partner/domestic partner, and the name of the employer. If coverage is waived you may in the future be able to enroll yourself and your eligible dependents in a SHBP medical or dental plan, provided that you request enrollment within 60 days after your other employer group health or dental coverage ends — proof of loss of coverage is required. See Fact Sheet #11, *Enrolling in the SHBP When You Retire*, for more information. Police and Firemen's Retirement System (PFRS) members enrolling under Chapter 330, P.L. 1997 should refer to Fact Sheet #47, *State Health Benefits Program Retired Coverage Under Chapter 330*, for more information.

LEVEL OF COVERAGE — Select a level of coverage based upon who you will be covering. Your eligible dependents are your spouse or civil union partner (attach a copy of the *Marriage Certificate* or *Certificate of Civil Union* if this is your first time enrolling in the SHBP), or an eligible same-sex domestic partner (see definition below), and your unmarried children under age 23 who live with you in a regular parent-child relationship. (This includes children who are away at school.) If you are divorced, your children who do not live with you are eligible if you are legally required to support those children. Step children, foster children, legally-adopted children, and legal wards are also eligible provided they live with you and are substantially dependent upon you for support and maintenance. An *Affidavit of Dependency* form and legal documentation are required for these cases if you have not previously provided this to the SHBP. You will be sent an *Affidavit of Dependency* if required once your application is received.

On your initial application at the time of retirement, you may add eligible dependents; thereafter, dependents may be added within 60 days of the date of event (i.e., marriage, civil union, birth of a child) with an effective date of the date of the event. Otherwise, eligible dependents can be added in the future, with a 60-day waiting period. Coverage will be effective the 1st of the month following the 60 days of the receipt of your application.

Indicate whether you and/or your spouse/civil union partner/domestic partner/child are enrolled in Medicare Parts A and B. Be sure to list the effective dates of the Medicare enrollment. Proof of Medicare enrollment is required by the State Health Benefits Program. Please submit a photocopy of the Medicare card or a letter from Social Security confirming the effective dates of enrollment. Members receiving a Social Security Disability who become Medicare eligible, must be enrolled in the full Medicare program — Part A and Part B in order to have coverage in the State Health Benefits Program. If submitting proof of Medicare enrollment, check the box at the bottom right of the application.

SPOUSE: This is a person of the opposite sex to whom you are legally married. A photocopy of the *Marriage Certificate* is required for enrollment.

CIVIL UNION PARTNER: This is 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 is required for enrollment. The cost of a civil union partner's coverage may be subject to federal tax (see Fact Sheet #75, *Civil Unions*, for details).

DOMESTIC PARTNER: This is a same-sex domestic partner, as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act, of any State employee, State retiree, or an eligible employee or retiree of a SHBP participating local public entity if the local governing body adopts 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 jurisdiction that recognizes same-sex domestic partners is required for enrollment. The cost of same-sex domestic partner coverage may be subject to federal tax (see Fact Sheet #71, *Benefits Under the Domestic Partnership Act*, for details).

SECTION 4 — DENTAL EXPENSE PLAN SELECTION

If eligible, check only one box indicating either: **1.)** that you want to enroll in the Dental Expense Plan; or **2.)** That you do not want dental coverage (See "Declining or Waiving Coverage" above); or **3.)** That you want to waive dental coverage. (See "Declining or Waiving Coverage" above)

Select a level of coverage based upon who you will be covering. See "Level of Coverage" above for details.

SECTION 5 — SPOUSE/PARTNER AND DEPENDENT INFORMATION

This section is used for members selecting Member & Spouse, Member & Civil Union Partner, Member & Domestic Partner, Family, or Parent & Child(ren) coverage. Please list your spouse's, civil union partner's, or domestic partner's name, gender, date of birth, Social Security number, and if appropriate, Primary Care Physician ID#. Please also list the name, gender, date of birth, Social Security number, and if appropriate the Primary Care Physician ID# for any dependent children you are enrolling. If you are listing more than two children, please provide the required information for your other children on an additional sheet of paper, attach the sheet to the application, and check the box at the bottom right of the application.

SECTION 6 — CERTIFICATION AND SIGNATURE

The member must read the certification and sign and date the application. If Medicare proof or additional sheets are submitted with the application, check the box indicating such.

Misrepresentation: Any person who provides false or misleading information is subject to criminal and civil penalties.

Return this application and all supporting documentation to:

**NJ DIVISION OF PENSIONS AND BENEFITS
HEALTH BENEFITS BUREAU
P.O. BOX 299
TRENTON, NJ 08625-0299
or Fax to: (609) 341-3407**