

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

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)

Status:
 -Single -Married -Civil Union -Domestic Partnership -Divorced -Widowed

(Area Code) Home Telephone Number
 - -

2. MEDICAL COVERAGE

2a. EMPLOYEE SELECTION

I wish to be covered under NJ DIRECT15.

I wish to be covered under NJ DIRECT10.
 (NJ DIRECT10 not available to State employees.)

I wish to be covered under Aetna HMO.
 (Enter Aetna HMO Primary Care Physician's ID#)

I wish to be covered under CIGNA HealthCare HMO.
 (Enter CIGNA HealthCare HMO Primary Care Physician's ID#)

I am changing medical plans only:
 From _____ to _____

I elect to waive medical coverage in any medical plan (see instructions).

2b. LEVEL OF COVERAGE

Single Member and Spouse/Civil Union Partner

Member and Domestic Partner (see instructions)

Family Parent and Child(ren)

3. PRESCRIPTION DRUG COVERAGE — See note below

3a. EMPLOYEE SELECTION

I wish to be covered by the Employee Prescription Drug Plan.

I elect to waive Employee Prescription Drug Plan coverage.

3b. LEVEL OF COVERAGE

Single Member and Spouse/Civil Union Partner

Member and Domestic Partner (see instructions)

Family Parent and Child(ren)

Note: Prescription Drug coverage is available to all State employees. Local/Educational employers must have elected to provide the SHBP Employee Prescription Drug Plan to employees as a separate prescription drug benefit to be eligible for this coverage. If you are eligible for prescription drug coverage through another employer provided plan, or if your employer does not provide a separate drug plan, do not complete this selection. (If your Local/Educational employer does not provide any separate drug coverage, your SHBP medical plan will include a prescription drug benefit.)

DIVISION USE ONLY

Effective Dates: _____ Event Reason: _____
 H _____
 P _____

EMPLOYER CERTIFICATION
See instructions on reverse

Employer Name: _____

Payroll # (State Biweekly) _____ Union Code (Rx) Only _____

Location # (State Monthly and Local/Educational)
 -

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 _____

4. DEPENDENT INFORMATION - List only eligible dependents (see instructions on reverse).

<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 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="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="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="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="text"/>	<input type="text"/>

5. TYPE OF ACTIVITY

(complete only if requesting changes to existing coverage)

5a. ADDITION OF DEPENDENT

Marriage - Date of Event (mm/dd/yy) _____
 (Copy of Marriage Certificate required)

Former Name _____

Civil Union/Domestic Partner - Date of Event (mm/dd/yy) _____
 (Copy of Certificate of Civil Union or Domestic Partnership required)

Birth of Child Adoption/Guardianship - proof required
 Date of Event (mm/dd/yy) _____

5b. DELETION OF SPOUSE OR PARTNER

Divorce Dissolution of Civil Union Death

Termination of Domestic Partnership

Date of Event (mm/dd/yy) _____

5c. DELETION OF CHILD

Deletion of Child - Date of Event (mm/dd/yy) _____

Child's Name _____

Child's SSN _____

Give Reason _____

5d. OTHER CHANGES

Change in last name only (Attach copy of supporting documentation)
 (List former name) _____

Change in Soc. Sec. # (Attach copy of Social Security card)
 (List former Soc. Sec. #) _____

Change in Birth Date (Attach copy of birth certificate)
 (List name and correct date) _____

Other - give reason (i.e., address change, dependent returns from military service) _____

6. 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 NJ DIRECT and HMO 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.

 Employee Signature

 Date Completed

INSTRUCTIONS FOR THE NJ STATE HEALTH BENEFITS PROGRAM APPLICATION STATE AND LOCAL EDUCATION/GOVERNMENT ACTIVE EMPLOYEE GROUP

- **To change your primary care physician (PCP)** with your HMO, contact your health plan directly. **DO NOT COMPLETE THIS FORM JUST TO CHANGE YOUR PRIMARY CARE PHYSICIAN.**
- **To enroll** for the first time, complete all sections of the application with the exception of section 5.
- **To change health plans only** complete sections: 1, 2a and 2b (if enrolling in an HMO be sure to list your primary care physician's identification number), 4 (listing all eligible dependents), and 6.
- **To change coverage level** (adding/deleting dependents) complete sections: 1, 2a and 2b, 3a and 3b (if SHBP prescription drug coverage is provided by your employer), 4 (listing all eligible dependents), 5 (listing why you are changing coverage level), and 6.
- **To add a dependent** complete sections: 1, 2a and 2b, 3a and 3b (if SHBP prescription drug coverage is provided by your employer), 4 (listing all eligible dependents), 5a, and 6.
- **To terminate/decline coverage** complete sections: 1, 2a and/or 3a (as applicable), and 6. (If you are eligible to waive coverage under the provisions of N.J.S.A. 52:14-17.31(a), you must also complete and attach the *Waiver/Reinstatement Declaration* form available from your employer.) If you are declining enrollment for yourself or any or all of your eligible dependents because of other group health insurance coverage, you may in the future be able to enroll yourself and/or your eligible dependents in a SHBP medical plan, provided that you request enrollment within 60 days after other group health coverage ends.

SECTION 1 - EMPLOYEE INFORMATION

This section must be completed in its entirety each time an application is submitted. The employee enrolling or enrolled in the plan completes this section.

SECTION 2 - MEDICAL COVERAGE

2a. Check only one box indicating the medical plan you wish to be enrolled in. If you do not want medical coverage or wish to cancel coverage, check the box to waive coverage.

2b. If you are electing coverage, check the level of coverage desired.

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 your employer or 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 your employer or Fact Sheet #71, *Benefits Under the Domestic Partnership Act*, for details).

SECTION 3 - PRESCRIPTION DRUG COVERAGE

The Employee Prescription Drug Plan is available to State employees and to only Local/Educational employees whose employers have adopted a resolution to provide this coverage. If the Employee Prescription Drug Plan is provided by your employer:

3a. To enroll, check the box to indicate that you wish to be covered. If you do not want prescription drug coverage or wish to cancel coverage, check the box to waive coverage.

3b. If you are electing coverage, check the level of coverage desired. (if enrolling a domestic partner, see eligibility information in "Domestic Partner" under 2b above).

NOTE: Once you decline or cancel Medical or Prescription Drug coverage, enrollment is not permissible until the next open enrollment period or if other coverage is lost and proof of loss is provided (HIPAA).

SECTION 4 - DEPENDENT INFORMATION

Only eligible dependents may be listed. Completion of this section is essential for proper enrollment. Be sure dependents listed agree with the level of coverage selected in sections 2b, and 3b. List the name, date of birth, gender, and Social Security number of the family members you wish to cover under the plan. You may list an eligible spouse, civil union partner, or same-sex domestic partner (see definitions in Section 2, above). If you have listed a child who is an adopted child, foster child, stepchild, legal ward, has a different last name than the employee, or if the member has a Parent/Child contract, proof of dependency is required (contact your payroll/personnel representative for an *SHBP Affidavit of Dependency* form). If you have more than four eligible dependent children, attach a separate application and complete Sections 1, 4, and 6. If enrolling in an HMO, include each dependent's HMO Primary Care Physician identification number — all dependents must have this information listed. Refer to the HMO plan's provider directory or Web site for this information, or call the HMO plan directly. Plan Web sites and phone numbers can be found on the *SHBP Plan Comparison Summary*.

NOTE: If you are deleting dependents, do not list them in this section. Refer to section 5b and 5c.

SECTION 5 - TYPE OF ACTIVITY

5a. If you are adding a dependent, check the appropriate box and indicate the event date.

5b. If you are deleting a dependent spouse, civil union partner, or domestic partner, check reason and indicate the event date.

5c. If you are deleting a dependent child, indicate the event date, list the child's Social Security number, and give reason.

5d. For other changes, check the appropriate box, give requested information, and attach a copy of supporting documentation if applicable.

SECTION 6 - EMPLOYEE CERTIFICATION

You must read the Employee Certification statement, **sign it, and date the application.**

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

EMPLOYER CERTIFICATION

Must be completed by your employer before submitting the application to the SHBP. By signing this application the employer certifies that:

- 1) The employee is eligible;
- 2) The application is legible and completed in its entirety;
- 3) The employee's selected plans and coverage levels are appropriate;
- 4) The Employer Certification section is completed in its entirety; and
- 5) The information presented is true to the best of their knowledge.