

School Employees' Health Benefits Program (SEHBP) EDUCATION ACTIVE EMPLOYEE GROUP

HEALTH BENEFITS ENROLLMENT and/or CHANGE FORM

1. EMPLOYEE INFORMATION — Last Name		First		Mi	DIVISION USE ONLY
					Effective Dates Event Reason:
Gender Birth Date		Social Securit	y Number	Marital Stat	us* Rx
/ /		_	_		EMPLOYER CERTIFICATION
Telephone Number		Persona	al Email Address	**************************************	(See Instructions on reverse) Employer
()					Name
Home Ad	ldress No.	and Street Name			Location # (State Monthly)
City		State		Zip	10/12 - month employee (Enter "10 or 12")
					MEMBER ACTION
2. EMPLOYMENT STATUS	☐ Part 1	ime 🔲 Nation	al Guard		☐ New Enrollment ☐ Transfer
3. REASON FOR APPLICATION (check one)		4. TYPE and LEV	EL OF COVERAGE		Date Employment Began
☐ New Enrollment ☐ Transfer		Level		Health Rx	1
☐ Open Enrollment ☐ Loss of Coverag	e	☐ Single			☐ Return from Leave of Absence
☐ Adding Dependents ☐ Deleting Depend		☐ Parent/Child			1
☐ Waiver of Coverage ☐ Other		☐ Member/Spot	use/Civil Union		
Reason		☐ Member/Dom	estic Partner		Signature of Certifying Officer
Date of Event//		☐ Family			Telephone # Date Mailed
I have been offered the above coverage and I	elect to w	l aive participation	for myself and my	eliaible deper	1 / / / / / / / / / / / / / / / / / / /
coverage is available under the medical plan.)		ct to waive Health C			escription Drug Coverage
5. HEALTH PLAN					AETNA
<u>HORIZON</u> ☐ NJ DIRECT ZERO	Пил	DIRECT2035	Па	tna Freedom	
☐ NJ DIRECT10		zon HMO		etna Freedom	
☐ NJ DIRECT15	☐ Hori	zon HMO1525	□ A∈	tna Freedom	15 🔲 Aetna HMO1525
☐ NJ DIRECT1525	☐ Hori	zon HMO2030	□ A∈	etna Freedom	1525 Aetna HMO2030
☐ NJ DIRECT2030	☐ Hori	zon HMO2035	☐ A∈	etna Freedom	2030
For HMO Plans only, enter Primary Care Ph	ysician's	ID #			
6. Dependent Information: List all eligible depe			•		
☐ Addition	al sheets	attached. Any dep	endents not listed	will be remov	/ed.
Eligible Dependents Last Name, First Name	Soc	ial Security No.	Circle Rel	ationship	Birth Date Gender
			Spouse / Civil Union	n / Domestic Pa	rtner / /
			Ch (Natural, Adopted, Fos		Ward) / /
			Ch	ild	, , ,
			(Natural, Adopted, Fos		
*See Ins	tructions	page for detailed i	nformation and Ma	iling Address	}
EMPLOYEE CERTIFICATION — I certify that a derstand that if I waive my right to coverage at lost and proof of loss is provided (HIPAA). I also or facilities, in the plans. If either my physician center participating in that plan to receive the "ir or its assignee with such medical information at knowingly provides false or misleading informat	his time, of understate or medical international internati	enrollment is not pe nd that there is no g center terminates benefit. I authorize f or my covered dep	rmissible until the ne guarantee of continuo participation in my so any hospital, physicio pendents as the assig	ext scheduled ous participati elected plan, l an, or health c nee may requ	open enrollment or if other coverage is on by medical providers, either doctors must select another doctor or medical are provider to furnish my medical plan tire. Misrepresentation: Any person that
7. Employee Signature:					Date: / /



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. Or, if tax return is not available, provide a copy of a bank statement or bill (dated within 90 day of the application) that includes the names of both spouses and is received at the same address.
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. Or, if tax return is not available, provide a copy of a bank statement or bill (dated within 90 day of the application) 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 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 the employee/retiree's N.J. tax return* from last year that includes the partner. If filing separately, submit a copy of both partners' N.J tax returns that list the same address. If Domestic Partnership occurred in the current calendar year, a copy of the tax return is not required. Or, if tax return is not available, provide a copy of a bank statement or bill (dated within 90 days of the application) 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 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 Guardian, 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



Explore Your Benefits AETNA AND HORIZON PLANS - MEDICAL PORTION ACTIVE GROUP LOCAL EDUCATION ACTIVE GROUP MEDICAL PLAN DESIGN - PLAN YEAR 2019 Explore Your Benefits AETNA AND HORIZON PLANS - MEDICAL COST SHARING

st Sharing NU		Aetna Freedom Zero	Aetna Freedom10	Aetna Freedom15	Aetna Freedom1525	Aetna Freedom2030	Aetna Freedom2035	Aetna HMO	Aetna HMO1525	Aetna HMO2030	Aetna HMO2035	Aetna Value HD1500*
st Sharing \$10 \$15 \$20 \$20 payment \$0 \$10 \$15 \$25 \$20 \$20 ropayment \$0 \$10 \$15 \$25 \$30 adult/ \$35 ropayment \$50 \$25 \$50 \$75 \$125 \$30 rible \$0 \$25 \$50 \$75 \$125 \$300 urance \$0 \$10%² \$10%² \$10%² \$10%² \$20% after urance \$0 \$400/\$\$1,000 \$400/\$\$1,000 \$400/\$\$1,000 \$2,000/\$\$2,000 \$2,000/\$\$2,000 r-Pocket \$1,000 \$1,000 \$12,640 \$12,		DIRECT ZERO	NJ DIRECT10	NJ DIRECT15	NJ DIRECT1525	NJ DIRECT2030	NJ DIRECT2035	Horizon HMO	Horizon HMO15251	Horizon	Horizon	NJ DIRECT
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F-Pocket \$400/ \$1,000 \$6,320/ \$1,000 \$6,320/ \$12,640 \$6,320/ \$12,640 \$6,320/ \$12,640 \$6,320/ \$12,640 \$12	etwork Coinsurance num (Individual/Family)			\$400/\$1,000	\$400/\$1,000	\$800/\$2,000	\$2,000/\$5,000					
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patient \$200/stay \$500/stay savings	nf-Network Out-of-Pocket num (Individual/Family)	\$2,000/ \$5,000***	\$2,000/ \$5,000	\$2,000/ \$5,000	\$2,000/	\$5,000/	\$6,500/					\$3,500/
Employer Health Savings	f-Network Inpatient ital Deductible				\$200/stay	\$500/stay	\$600/stay					000,74
Account Funding-	Employer Health Savings Account Funding⁵											\$300