HA-0109-0519

State Health Benefits Program (SHBP) • School Employees' Health Benefits Program (SEHBP)

ACTIVE LOCAL GOVERNMENT AND LOCAL EDUCATION EMPLOYEE GROUP

EMPLOYEE COVERAGE WAIVER/REINSTATEMENT FORM

PART 1: EMPLOYEE INFORMATION — Last Name | First | MI

Gender	Birth Date	Social Security Number	Marital Status*
	/ /	— —	

Telephone Number: ( )

Personal Email Address:

Home Address No. and Street Name:

City | State | Zip

EMPLOYMENT STATUS ☐ Full Time ☐ National Guard

DIVISION USE ONLY

Effective Dates: H _____ _____ _____ Rx _____ _____ _____

Event Reason: ☐

EMPLOYER CERTIFICATION

(See Instructions on reverse)

Employer Name _____

Location # (State Monthly) ☐☐☐☐☐☐☐

10/12 - month employee ☐☐ *(Enter "10 or 12")*

MEMBER ACTION

☐ New Enrollment ☐ Existing

Date Employment Began

_____/_____/_____

_____

Signature of Certifying Officer

_____

Telephone # *Date Mailed*

Check one box below.

☐ **Waiver of Coverage**

In accordance with P.L. 2007, c. 92 (Chapter 92) and P.L. 2010, c. 2 (Chapter 2), I have agreed to waive coverage (medical and, if applicable, prescription drug coverage) with the State Health Benefits Program (SHBP) or School Employees' Health Benefits Program (SEHBP) to which I am entitled because I am covered under other health coverage. I understand that I am not eligible for the waiver incentive if my other coverage is with the SHBP or SEHBP. **Note:** You must submit proof of the other health coverage to your employer along with this form.

In place of health benefit coverage, my employer will pay me the amount shown in Part 2 below. I understand that I may resume SHBP or SEHBP coverage when I am no longer covered by the other health coverage, provided that I notify the Health Benefits Bureau within 60 days of the loss of the other coverage and provide proof of loss of that coverage.

I wish to waive *(check one)* ☐ Medical Coverage ☐ Prescription Coverage ☐ Both

☐ **Reinstatement of Coverage**

I previously waived SHBP or SEHBP coverage because I had other health coverage. As of _____/_____/_____, I am no longer covered by the other health plan, request reinstatement of health benefits coverage with the SHBP or SEHBP, and have provided proof of loss of the other coverage. I further understand that coverage is permitted as an employee, retiree, or dependent; however, multiple coverage under the SHBP or SEHBP is prohibited. A *Health Benefits Enrollment and/or Change Form*, along with proof of loss of other coverage, is required for all reinstatements.

Employee's Signature _____ **Date** _____/_____/_____

PART 2: To be completed by the employer. Check one box below.

☐ We will pay the above employee $_____ every _____ in place of providing SHBP or SEHBP coverage. We understand that this payment may not be more than 25 percent of the amount saved by the employer because of the waiver or $5,000, whichever is less.

☐ We request reinstatement of this employee's SHBP or SEHBP coverage.

The reinstatement application must be filed within 60 days of the loss of other health coverage. If this timetable is followed, the coverage will be retroactive to the date of loss. If the 60 day time limit has passed, the employee must wait until the next open enrollment period to reenroll.

MAIL COMPLETED APPLICATION TO:

New Jersey Division of Pensions & Benefits
Health Benefits Bureau
P.O. Box 299
Trenton, NJ 08625-0299