**Office of Human Resources**
**70 Sip Avenue – 3rd Floor**
**Jersey City, NJ 07306**
**201-360-4070 Office**
**201-714-2509 Fax**

TO: New Hire

FROM: Human Resources

RE: **NJ School Employees'**
Health Benefits Program (SEHBP) Enrollment

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**HCCC Local Education Employees**

The New Jersey Employees' Health Benefits Program (SEHBP) and the New Jersey Division of Pensions & Benefits (NJDPB) require eligible employees to access *Benefitsolver* online, for accessing all your health benefit enrollment needs, including the fall Annual Open Enrollment period (October 1-31).

Through *Benefitsolver*, you can access information about your health benefits and complete your enrollments online. You can view your coverage, effective dates, who is covered under your plan and have access to live chat with any questions you may have, in reference to your SEHBP coverage. *Same access is available for those who wish to waive health & prescription coverage.*

To Register:
Navigate to: http://mynjbenefitshub.nj.gov
a) Click Register
b) Enter SSN and DOB
c) Enter Company Key: SHBP/SEHBP
d) Click continue

If you have trouble accessing the *BenefitSolver* website or have any questions in regards to your benefits, please do not hesitate to contact the HR Benefits Manager.

Thank you,
*Office of Human Resources*

# How to access your benefits

Welcome

**First time here?**

Register to create your user name and password.

Register

Welcome

**User Name** *

case sensitive

**Password** *

case sensitive

Login

State of New Jersey Annual Open Enrollment is Here!

State of New Jersey Annual Open Enrollment Ends October 31st.

Days Left

Start Here

Home | Change My Benefits | My Benefits | Contacts

WELCOME TO mynjbenefitshub

Benefit Guide | Change My Benefits | Earn My NJWELL Reward | Find a Provider

Contacts | Additional Benefits | Change My Address or Email | Plan Details

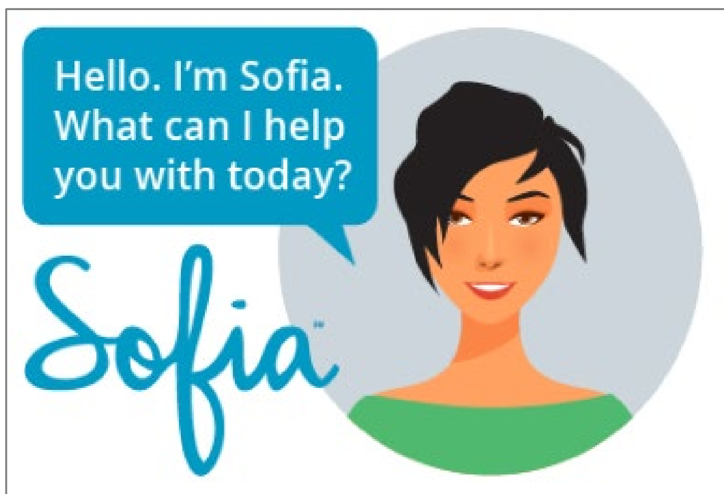
Important Reminders

Action Required

State of New Jersey Annual Open Enrollment — Start Here

Review my current coverage

Benefit Summary




## HOW TO LOGIN:

Navigate to: http://mynjbenefitshub.nj.gov and click Register.

Enter Social Security Number and Date of Birth.

Company Key = SHBP/SEHBP

*You may also log into the Benefitsolver website through the myNewJersey portal. At the bottom of the screen along with your MBOS and EPIC button, you'll see a new button that reads "Benefitsolver".*

## LET'S KEEP IN TOUCH

You'll be asked to provide an email address so we can send you the latest information on your benefits, including **Annual Open Enrollment Information.**

## DISCOVER YOUR SITE

Explore the site to learn about your benefits. You'll find lots of helpful information in the **Reference Center**.

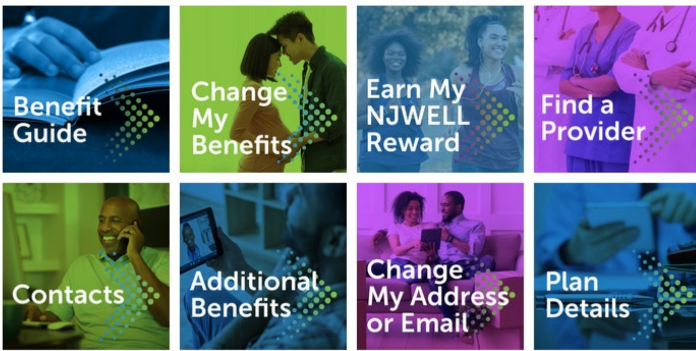
## REVIEW YOUR BENEFITS

Click the **Benefit Summary** button on the home page to review your personal information, your covered dependents, and your medical, prescription, and dental plan details.

## FOR HELP

Sofia, your personal benefits assistant, can answer questions and guide you through the site.

Contact your local Human Resources Department, Benefits Administrator, or your Certifying Officer for additional assistance.




Search Reasons for Change

Select the reason for change that applies and enter the date of the event.

| ENROLLMENT | BASIC INFO | LIFE EVENT |
| --- | --- | --- |
| Examples: New Hire Enrollment, Open Enrollment | Examples: Change of Address, Change of Beneficiary | Examples: Marriage/Divorce, Birth/Death |
| State of New Jersey Annual Open Enrollment | Address and Phone Number Information Change | Add Child age 27 to 31 Ch 375 Coverage |
| | | Birth or Adoption |
| | | Death of Dependent |
| | | Divorce |
| | | Drop Coverage on Demand-Please Enter Today's Date |
| | | Gains Coverage Elsewhere |
| | | Loses Coverage Elsewhere |
| | | Marriage |
| | | Return From LOA |
| | | Update Dependent Demographic Information Only |

Transaction Complete

Benefit Summary PDF

Your information has been submitted.

Select Home to return to your benefits home page or Log Out to end this session.

Thank You.

Confirmation Number

123-53-04-4539

Important Reminders 2

**Action Required**

State of New Jersey Annual Open Enrollment - Complete — Review

State of New Jersey Annual Open Enrollment - Pending Dependent Verification — Upload Documents

my choice Mobile App

## MyChoice Mobile App

- Quick access to benefit details
- Store your ID Cards

Get Access Code

## CHANGE YOUR BENEFITS OR INFORMATION

To report a Qualifying Life Event, such as a Marriage or Birth/Adoption in the last 60 days, start by clicking the **Change My Benefits** button.

Select your Life Event from the **Life Event** box and enter the effective date of the change.

To change your contact information, start by clicking the **Change My Address or Email** button.

## CONTINUE YOUR CHANGE

The next set of screens will walk you through your enrollment step by step, showing you the available options relevant to the change you'd like to make.

Make sure your personal information, elections, and dependents are accurate, then click **Looks Good!**

To complete your transaction, click **Approve**. On the Confirmation screen, click **I Agree.**

If you've added new dependents, you will be prompted to provide supporting documentation. Your employer will verify all uploaded documents before your dependent is approved.

When your enrollment is complete, you will receive a confirmation number and can print your **Benefit Summary** for your records.

## AFTER YOU ENROLL

Return to the Home page to check for any additional tasks needed to complete your enrollment. View or download your Benefit Summary, and download the **MyChoice Mobile App**.

Visit this site anytime you want to learn more about your benefits or even search for a new provider and book an appointment using **Amino!**

# INDIVIDUAL ENROLLMENT/CHANGE FORM

FOR VISION COVERAGE

(Please Print or Type)

| EMPLOYER: Hudson County Community College | | | GROUP NO: 4079 0000 01-99 |
|---|---|---|---|
| LAST NAME: | FIRST NAME: | MI | DATE OF BIRTH |
| STREET ADDRESS | CITY | STATE | ZIP |
| SOCIAL SECURITY NUMBER<br>__ __ | GENDER<br>☐ Male<br>☐ Female | CONTRACT TYPE REQUESTED<br>☐ Single *$5.30*<br>☐ Employee + Spouse *$10.61*<br>☐ Employee + Child(ren) *$16.97*<br>☐ Family (Employee, Spouse, Child(ren)*$20.16* | |
| EFFECTIVE DATE OF COVERAGE *OR* CHANGE: ______________________ | DATE OF HIRE: ___________________________ | | |

**COMPLETE THE FOLLOWING FOR ALL FAMILY MEMBERS FOR WHOM YOU ARE REQUESTING COVERAGE**

**PLEASE CHECK THE APPROPRIATE ACTION CODES FOR CHANGES**

THIS CHANGE IS FOR: ☐ EMPLOYEE ☐ SPOUSE ☐ DEPENDENT(S)

TYPE OF CHANGE: ☐ NEW ENROLLMENT ☐ CHANGE OF ADDRESS ☐ NAME CHANGE ☐ REINSTATEMENT ☐ CHANGE TO COBRA

☐ ISSUE CARD ☐ CANCEL COVERAGE ☐ NAME CHANGE, FORMERLY ______________________

| LAST NAME | FIRST NAME | INITIAL | M / F | DATE OF BIRTH | STUDENT (Y/N) |
|---|---|---|---|---|---|
| Spouse | | | | | |
| Dependent | | | | | |
| Dependent | | | | | |
| Dependent | | | | | |
| Dependent | | | | | |

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST ANY INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

I HEREBY APPLY FOR ENROLLMENT FOR VISION COVERAGE.

EMPLOYEE SIGNATURE: **X** ________________________________________ DATE: ____________________

EMPLOYER SIGNATURE: **X** ________________________________________ DATE: ____________________

**This document has been printed on recycled paper.**

# Enrollment/Change Request

Employer Group Information – To be completed by Employer

Group Name: HCCC
Group Number: 07563
Sublocation/Store location: 00001 / ________

**(A) Type of Activity – To Be Completed by Employer. Refer to instructions on back before completing this form. Print clearly.**

**1. Enrollment ( ) New Enrollee / Subscriber** **Effective Date ___/___/___** **Date of Hire ___/___/___**

| **2. Change – Check all that apply** | Date of Event | Reason |
|---|---|---|
| ( ) Add Spouse | __/__/__ | ________ |
| ( ) Add Domestic Partner | __/__/__ | ________ |
| ( ) Add Dependent Child | __/__/__ | ________ |
| ( ) Name Change | __/__/__ | ________ |
| ( ) Change Plan | __/__/__ | ________ |
| ( ) Other | __/__/__ | ________ |
| ( ) Add/Change Office ID Numbers | __/__/__ | ________ |

| 3. Remove or Terminate – Check all that apply | Effective Date | Reason |
|---|---|---|
| ( ) Remove Spouse* | __/__/__ | ________ |
| ( ) Remove Domestic Partner* | __/__/__ | ________ |
| ( ) Remove Dependent Child* | __/__/__ | ________ |
| ( ) Employee Withdrawal/Termination | __/__/__ | ________ |

NOTE: Employee must be enrolled for spouse/dependents(s) to have coverage.

*Please complete *Add/Change/Remove* and *Name* columns in Section D.

**4. Continuation of coverage, i.e. COBRA, State, total disability. Not all options are available or applicable. Contact Employer for available options.**

**Coverage for:** **( ) Employee** **( ) Dependents**

Length of Continuation: ( ) 12 months ( ) 18 months ( ) 29 months ( ) 36 months ( ) Total Disability* Attach proof of total disability

Date of Loss of Coverage: __/__/__ Date of Qualifying Event: __/__/__

Billing: ( ) Home ( ) Group

**(B) Employee Information – Complete Sections (B-G)**

Last name, First name, MI ________ Social Security Number ________ Home Telephone ________

E-mail Address ________ Home Address ________ Apt # ____ City, State ________ Zip Code ______

Employer Name ________ Work Telephone ________ Work Address ________

City, State ________ Zip Code ________ Date of Employment __/__/__ Hours Worked per week ________

**(C) Plan Option** – Your selection must be offered by your Employer Check one: ( ) Delta Dental Premier® ( ) Delta Dental PPO ( ) Advantage Program ( ) Delta Dental PPO plus Premier ( ) DeltaCare

**(D) Individuals Covered** – List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. (Attach proof if full-time post-secondary student. Attach proof of disability.)

| | (A) Add (C) Change (R) Remove | Last Name First Name, MI | Sex M F | Birthdate MM/DD/YYYY | Social Security Number | Other Health Coverage | Previous Coverage Check if Yes |
|---|---|---|---|---|---|---|---|
| Employee | ________ | ________ | ____ | __/__/____ | ________ | ________ | ______ |
| Domestic Partner (If Coverage offered) | ________ | ________ | ____ | __/__/____ | ________ | ________ | ______ |
| Spouse | ________ | ________ | ____ | __/__/____ | ________ | ________ | ______ |
| Child | ________ | ________ | ____ | __/__/____ | ________ | ________ | ______ |
| Child | ________ | ________ | ____ | __/__/____ | ________ | ________ | ______ |
| Child | ________ | ________ | ____ | __/__/____ | ________ | ________ | ______ |
| Child | ________ | ________ | ____ | __/__/____ | ________ | ________ | ______ |

**(E) Other/Previous Insurance**

Is your spouse employed? ( ) Yes ( ) No If “Yes”, give name and address of your spouse’s employer.

________________________________________

If “Yes” to Other Health Coverage (Section D), give names & policy numbers of insurance carrier, HMO, or other source. If enrolled in Medicare Parts A and/or B, identify the coverage and provide the Medicare ID#.

______________________________________________________________________________________________

If “Yes” to Previous Coverage, identify names(s) of persons, give effective date and date coverage terminated, name of previous carrier and plan number.

______________________________________________________________________________________________

**(F) Dependent Information**

Does any dependent listed in Section D live at a different address than the Employee? ( ) Yes ( ) No If “Yes”, who and at what address?

______________________________________________________________________________________________

Explain the circumstances

______________________________________________________________________________________________

If any dependent’s last name differs from yours, explain the circumstances.

______________________________________________________________________________________________

**(G) Employee Signature** *If you have questions concerning the benefits and services provided by or excluded under this Agreement, contact a Customer Service Agent at 1-800-452-9310 before signing this form.*

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the reverse side of the employee enrollment/change request. I authorize deductions from my earnings for any required contributions.

Employee Signature – Required ______________________________ Date __/__/__ E-mail Address ______________________________

**(H) Employer Verification –** To be Completed by Employer

Employer Signature – Required ______________________________ Title ______________________________ Date __/__/__

**Instuctions**

**Employer**

*Complete the Employer Group Information in the upper left corner of the form.
*Section A - Type of Activity:Check boxes indicating reason(s) for submitting application.
*Complete Section (H) – Employer Verification (in the upper left corner of the second page)of the form.
*Employer must complete this section for all new enrollments, coverage changes and terminations.
*Employer must sign and date the Enrollment/Change Request in order for it to be processed.

**Employee – Complete Sections (B-G)**

**Section (B) – Employee Information**

- Complete all information in order for your application to be processed.

**Section (C) Plan Option:**

Check one Plan option box ( ) Delta Dental Premier ( ) Delta Dental PPO
( ) Delta Dental POS ( ) Delta Dental PPO Advantage Program ( ) DeltaCare
Select only an option offred by your employer.

**Section (D) – Individuals Covered:**

- Add/Change/Remove – Use “A”,“C”,or”R” to indicate wqhether you are adding,changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependents, if applicable. Indicate Sex,Birthdate,and Social Security number for each individual listed.
- If a dependent is a full-time post-secondary student, you must attach a current course schedule or a letter from the school **or its authorized representative** confirming full-time student status. If dependent is disabled and being contiuned beyond the limiting age, attach proof of disibility.
- If you or your dependent(s) have other Health coverage, check off the “Yes” box(es) and complete Section (F) – Other/Previous Insurance.
- From the appropriate provider directory, locate the office ID number for the dentist (if applicable). Indicate office ID number selection(s) on the form.

**Section (E) – Pre-Existing Conditions Statement**

- Complete this section for all new enrollments. Exceptions: For Small Employer Group coverage, this section must be completed only by persons enrolling in the group coverage in a group of 2-5 employees and by late entrants.

**Section (F) – Other/Previous Insurance**

- Complete this section for all new enrollments or coverage changes. Coverage includes group coverage, governmental coverage, a church plan or Medicare.

**Section (G) – Dependent Information**

- Complete this section for all new enrollments or coverage changes.

**Section (H) – Employee Signature:**

- Complete this section for all new enrollments, coverage changes and terminations.
- Employee must sign and date the Enrollment/Change Request Form in order for it to be processed.

**Section (I) – Employer Verification**

- Employer must complete this section for all new enrollments, coverage changes and terminations.
- Employer must sign and date the Enrollment/Change Request Form in order for it to be processed.

**Conditons of Enrollment**

**Application Acknowledgment and Agreements**

1. On behalf of myself and the dependents listed on the reverse side I agree to or with the following:
   a)I authorize the sources stated below to give Delta Dental of New Jersey, Inc. or any consumer reporting agency acting on its behalf, information about me and my minor childern, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, treatment or supplies for any physical or medical condition. Authorization sources are any physician or medical professional; any hospital, clinic or other medical care institution; any carrier, any consumer reporting agency; any employer.
   b) I understand that I may revoke this authorization at any time. I agree that such revocation will not afect any action which Delta Dental of New Jersey, Inc. has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
   c) I know that I have a right to receive a copy of the authorization if I request one.
   d) I agree that a photocopy of this authorization is as valid as the original.
2. I acknowledge by enrolling in a Delta Dental of New Jersey, Inc. plan or group policy coverage is provided by Delta Dental of New Jersey, Inc. in accordance with the contract.
3. Enrollment of myself and of the listed dependents into the plan is effective on acceptance by Delta Dental of New Jersey, Inc.
4. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. My employer is hereby authorized to withhold payments from my wages, as appropriate.

**Misrepresentation**

5. Any person who includes any false or misleading information on an Enrollment/Change Request form for a health benefits plan is subject to criminal and civil penalties.