

STATE OF NEW JERSEY
DEPARTMENT OF THE TREASURY
DIVISION OF PENSIONS AND BENEFITS
PO BOX 299
TRENTON, NJ 08625-0299

STATE HEALTH BENEFITS PROGRAM

**Waiver of State Health Benefits Program Coverage
While on Military Duty**

Part 1: To be completed by the employee. Please print.

Name: _____ **SS#:** _____

Employer Name: _____

Part 2: Check only one box.

I hereby waive my SHBP coverage while I am on military duty. I understand that by signing this waiver, SHBP coverage for myself, and any covered dependents, will end. I further understand that my coverage will be reinstated upon my return to regular employment after I submit a SHBP Enrollment Application.

I wish to continue my SHBP coverage for myself, and any covered dependents, while I am on military duty. I understand that I am responsible for any normal employee contributions for this coverage. If any differential pay I receive is insufficient to cover these required employee contributions, I understand that I will be required to pay the contributions upon my return from military duty.

Part 3: Sign and date this form.

Employee's Signature: _____ **Date:** _____