HD-1172-0825

State of New Jersey • Department of the Treasury

DIVISION OF PENSIONS & BENEFITS — HEALTH BENEFITS SECTION

P.O. Box 295, Trenton, NJ 08625-0295

P.L. 1999, c. 48 (CHAPTER 48) — EMPLOYER CERTIFICATION FOR DENTAL BENEFITS

To be completed by the employing agency's Health Benefits Certifying Officer.

Retiree's Name _____ Social Security Number _____

Employer Name _____ Health Benefits Employer ID Number_____- ___

PART 1 — ELIGIBILITY

☐ Retiree is not eligible for employer paid dental benefits under the provisions of Chapter 48; OR

☐ I certify that the above-stated retiree has the required months of service with this employer and meets any other criteria specified for the benefits under the provisions of Chapter 48 which are indicated below.

Note: Retirees required to pay a premium share will have the payments taken from their monthly pension check, provided the check is large enough.

PART 2 — DENTAL BENEFITS

Percent _____ % or flat amount $_____ paid monthly by employer for dental benefits for member; AND

Percent _____ % or flat amount $_____ paid monthly by employer for dental benefits for ☐ all dependents

☐ spouse only

Flat amount $ _____to be paid monthly by employer for all coverage levels.

PART 3 — LIMITATIONS (if none indicated, benefits apply as long as employer participates in the SHBP)

If employer-paid benefits in retirement are for a specified limited time, employer payment of dental benefits will terminate upon:

☐ Retiree attains age _____ ; OR

☐ Time limit of _____ months (please convert years to months); OR

☐ Specified date that health benefits will terminate _____/_____/_____

PART 4 — SURVIVING SPOUSE OR PARTNER DENTAL BENEFITS

Employer-Paid Surviving Spouse or Partner Coverage ☐ Yes ☐ No

If Yes, will dental benefits for the surviving spouse or partner be the same as the member? ☐ Yes ☐ No

Note: A new certification form will be needed if the spouse/partner becomes eligible for survivor benefits.

PART 5 — CERTIFICATION

_____ _____ _____/_____/_____

Print Health Benefits Certifying Officer Name *Signature* *Date*

_____ _____

Phone Number *Email Address*

Please return this form to:

State Health Benefits Program
Health Benefits Bureau
P.O. Box 299
Trenton, NJ 08625-0299

Or Email:

Your Designated NJDPB Health Benefits Group Email Box found on the Resources & Support page in your Benefitsolver Administrator account.