STATE OF NEW JERSEY

DEPARTMENT OF THE TREASURY - DIVISION OF PENSIONS AND BENEFITS

NEW JERSEY STATE HEALTH BENEFITS PROGRAM

PO BOX 299 TRENTON, NEW JERSEY 08625-0299

This form is to be completed for all employees retiring from a local contributory or noncontributory retirement program who may be eligible for retired group coverage in the State Health Benefits Program.

INDIVIDUAL RETIREMENT CERTIFICATION

Name of Retiree: _____ Date of Retirement: _____

Years and months of creditable service at retirement: _____

Please check one: ☐ _____
Name of Local Contributory Pension Fund

☐ _____
Statutory Citation, if noncontributory benefit

Was the individual covered by the employer's health benefits program? ☐ Yes ☐ No
Was the individual a part-time employee? ☐ Yes ☐ No
Was the individual retired on a disability pension? ☐ Yes ☐ No

I certify that the information given is based upon available authentic public records and that they are true and correct to the best of my knowledge.

COUNTERSIGNED:

(Please print or type)

_____
Name of Retiree

_____
Date of Birth

_____
Social Security Number

_____
Retiree's Signature

(Please print or type)

_____
Name of Employing Agency

_____
Name of Remitting Agent for Health Benefit Premiums

_____
Signature

_____
Date