



**For Employer Use Only**  
(forms submitted by members will not be accepted)

State of New Jersey • Department of the Treasury  
**DIVISION OF PENSIONS & BENEFITS — HEALTH BENEFITS BUREAU**  
P.O. Box 299, Trenton, NJ 08625-0299  
**ACTIVE SHBP/SEHBP MANUAL OVERRIDE FORM**

**Note:** Override request must be reviewed and approved by NJDPB staff

**PART 1 — MEMBER INFORMATION**

Member's Name \_\_\_\_\_  
*Last* *First* *MI*

Member's Social Security Number \_\_\_\_\_ Gender \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status \_\_\_\_\_

Street Address \_\_\_\_\_  
*Street* *City* *State* *Zip*

Phone Number \_\_\_\_\_ Email \_\_\_\_\_

**Member Action (Choose one)**

New Enrollment (Date Employment Began) \_\_\_\_\_  
*Month* *Day* *Year*

Transfer Date \_\_\_\_\_  
*Month* *Day* *Year*

Return From Leave Of Absence \_\_\_\_\_  
*Month* *Day* *Year*

Other Reason (Effective Date) \_\_\_\_\_  
*Month* *Day* *Year*

Reason \_\_\_\_\_  
\_\_\_\_\_

**Level of Coverage (Choose one)**

- Member Only
- Member + Spouse/Civil Union/Domestic Partner
- Member + Child
- Family

**Continued on Page 2**

## PART 2 — DEPENDENT INFORMATION

List all eligible dependents and attach required proof of dependency documents. Find documentation requirements on the "I Want to Learn About Dependent Verification" page on mynjbenefitshub. Dependents not listed will be removed from coverage.

**Dependent 1:** Name \_\_\_\_\_  
*Last* *First* *MI*

Relationship to Member      Spouse      Civil Union Partner      Domestic Partner

Social Security Number \_\_\_\_\_ Gender \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

**Dependent 2:** Name \_\_\_\_\_  
*Last* *First* *MI*

Social Security Number \_\_\_\_\_ Gender \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Child's Relationship to Member

Natural Child      Adopted Child      Stepchild      Foster Child      Legal Ward

**Dependent 3:** Name \_\_\_\_\_  
*Last* *First* *MI*

Social Security Number \_\_\_\_\_ Gender \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Child's Relationship to Member

Natural Child      Adopted Child      Stepchild      Foster Child      Legal Ward

**Dependent 4:** Name \_\_\_\_\_  
*Last* *First* *MI*

Social Security Number \_\_\_\_\_ Gender \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Child's Relationship to Member

Natural Child      Adopted Child      Stepchild      Foster Child      Legal Ward

**Continued on Page 3**

**PART 3 - APPEAL INFORMATION**

Employer Name \_\_\_\_\_

Employer Group Type                      State                      Local Government                      Education

Payroll Number (State Biweekly) \_\_\_\_\_                      Employer ID/Location Number \_\_\_\_\_ - \_\_\_\_\_

10/12 Month Employee? \_\_\_\_\_                      Plan Type                      Medical Plan Election                      Dental Plan Election

Plan Name and Carrier (Example: Horizon NJ DIRECT10) \_\_\_\_\_

Reason for Appeal

Certifying Officer's Signature \_\_\_\_\_

Certifying Officer's Phone Number (\_\_\_\_\_) \_\_\_\_\_

Date of Appeal Request \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Return completed form to:                      Your Designated NJDPB Health Benefits Group Email Box found on the Resources & Support page in your Benefitsolver Administrator account.**