HB-1165-0524

State of New Jersey • Department of the Treasury

DIVISION OF PENSIONS & BENEFITS — HEALTH BENEFITS BUREAU

P.O. Box 299, Trenton, NJ 08625-0299

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

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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

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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:

Email: **Your Designated NJDPB Health Benefits Group Email Box:**

HBStateColleges@treas.nj.gov
HBStateActive@treas.nj.gov
HBLocalGov@treas.nj.gov
SEHBP@treas.nj.gov

Fax: **(609) 341-3407**

Mail: **New Jersey Division of Pensions & Benefits**
Health Benefits Bureau
P.O. Box 299
Trenton, NJ 08625-0299