HB-1166-0825

State of New Jersey • Department of the Treasury

DIVISION OF PENSIONS & BENEFITS — HEALTH BENEFITS BUREAU

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

RETIREE SHBP/SEHBP MANUAL OVERRIDE FORM

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

PART 1 — RETIREE INFORMATION

Retiree's Name _____ _____ _____
Last *First* *MI*

Retiree's Social Security Number _____ Gender _____

Date of Birth _____/_____/_____ Marital Status _____

Street Address _____
Street *City* *State* *Zip*

_____ _____
Phone Number *Email Address*

Former Employer _____

Were you a part-time employee when you retired? ☐ Yes ☐ No

Level of Coverage (Choose one)

☐ Member Only ☐ Member + Spouse/Civil Union/Domestic Partner

☐ Member + Child ☐ Family

Medicare Coverage – Part A (Hospital Insurance), Part B (Medical Insurance)

I am enrolled in ☐ Part A ☐ Part B ☐ Neither Part A or Part B

My spouse/civil union/domestic partner is enrolled in ☐ Part A ☐ Part B ☐ Neither Part A or Part B

My child is enrolled in Medicare ☐ Yes ☐ No

Medicare proof enclosed ☐ Acceptable proof is a copy of your Medicare ID card or a letter of confirmation from Social Security stating the effective dates of Medicare Parts A and B and your Health Insurance Claim Number (HICN) or Medicare Beneficiary Identifier (MBI) number.

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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

Change Requested ☐ Medical Plan Election ☐ Dental Plan Election

Plan Name and Carrier (Example: Horizon NJ DIRECT 15) _____

Reason for Appeal

☐ New Retiree Missed Initial Enrollment Window (Retirement Date) _____/_____/_____

☐ Other Reason (Effective Date) _____/_____/_____

Explain other reason _____

_____

_____

Disability Retirees Only: When you submit your application, the SHBP/SEHBP will enroll you on the first of the month following the date of your Board approval. However, you may choose to enroll retroactively (up to one year in the past). You will be charged retroactively for any health benefit and dental premiums.

☐ I wish to be enrolled timely ☐ I wish to be enrolled retroactively

Retiree Certification

I certify that all the information supplied on this form is true to the best of my knowledge. I authorize a health premium deduction from my pension check, including initial check, last check benefit, withdrawal check, or return of contributions check as required by the State Health Benefits Commission and School Employees' Health Benefits Commission. I also understand that there is no guarantee of continuous participation by medical service providers, either doctors or facilities in the plans. I authorize any hospital, physician, or health care provider to furnish my medical plan or its assignee with such medical information about myself, or my covered dependents on this application, as the assignee may require. Anyone eligible for Medicare (age 65 or older or in receipt of Social Security Disability benefits for at least 24 months) must be enrolled under both Hospital Insurance (Part A) and Medical Insurance (Part B) in order to continue coverage under this program. PROOF OF ENROLLMENT IS REQUIRED. If I, or a covered dependent, enroll in Medicare at a later date, I understand that the Health Benefits Bureau must be notified immediately. Misrepresentation: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties pursuant to N.J.S.A. 17:33A-6c.

Retiree's Signature _____

Date of Appeal Request _____ / _____ / _____

Return completed form to:

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

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