HA-1057-0819

IFPTE/AFSCME OPEN ENROLLMENT

State Health Benefits Program (SHBP)

STATE ACTIVE EMPLOYEE GROUP

HEALTH BENEFITS ENROLLMENT and/or CHANGE FORM

1. EMPLOYEE INFORMATION — Last Name | First | MI

Gender	Birth Date	Social Security Number	Marital Status*
	/ /	— —	

Telephone Number	Personal Email Address
( )	

Home Address No. and Street Name

City | State | Zip

DIVISION USE ONLY

Effective Dates — Event Reason:

H ____ ____ ____

Rx ____ ____ ____

EMPLOYER CERTIFICATION

(See Instructions on reverse)

Employer Name _____

Payroll # _____

(State Biweekly only)

Union Code (Rx) Only *(State only)* ☐☐☐

Location # *(State Monthly only)* ☐☐☐☐☐☐☐

10/12 - month employee *(Enter "10 or 12")* ☐☐

MEMBER ACTION

☒ Open Enrollment

_____

Signature of Certifying Officer

_____

Telephone # — *Date Mailed*

2. EMPLOYMENT STATUS

☐ Full Time ☐ Part Time ☐ Intermittent ☐ National Guard ☐ ACA *(monthly only)*

3. HEALTH PLAN *(check one box only)*

Horizon	Aetna
☐ NJ DIRECT/NJ DIRECT 2019*	☐ Aetna Freedom/Aetna Freedom 2019*
☐ Horizon HMO	☐ Aetna HMO
☐ OMNIA Health Plan	☐ Aetna Liberty Plan
☐ NJ DIRECT HD1500	☐ Aetna Value HD1500
☐ NJ DIRECT HD4000	☐ Aetna Value HD4000

**Members enrolled prior to July 1, 2019, will be enrolled in NJ DIRECT or Aetna Freedom. Members enrolled after July 1, 2019, will be enrolled in NJ DIRECT 2019 or Aetna Freedom 2019.*

For HD Plans only – Health Savings Account (HSA)

☐ I wish to establish a HSA at this time and understand that I will be contacted to establish banking. By applying for and funding my HSA I represent that I:

1) am covered under a High Deductible Health Plan (HDHP);

2) am not covered by any other non-HDHP product;

3) am not covered in Medicare; and

4) cannot be claimed as a dependent on another person's tax return.

☐ I am not enrolling in a HSA at this time and understand that if I choose to at a later date, I must contact my health plan.

4. DEPENDENT INFORMATION: Be sure to include all dependents currently on your health plan. You may not add dependents during this special Open Enrollment period. ☐ Additional Sheets attached.

Eligible Dependents Last Name, First Name	Social Security No.	Circle Relationship	Birth Date	Gender
	— —	Spouse Civil Union/Domestic Partner	/ /	
	— —	Child (Natural, Adopted, Foster, Step, Legal Ward)	/ /	
	— —	Child (Natural, Adopted, Foster, Step, Legal Ward)	/ /	

EMPLOYEE CERTIFICATION — I certify that all the information supplied on this form is true to the best of my knowledge and that it is verifiable. I understand that if I waive my right to coverage at this time, enrollment is not permissible until the next scheduled open enrollment or if other coverage is lost and proof of loss is provided (HIPAA). I also understand that there is no guarantee of continuous participation by medical providers, either doctors or facilities, in the plans. If either my physician or medical center terminates participation in my selected plan, I must select another doctor or medical center participating in that plan to receive the "in-network" benefit. 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 as the assignee may require. **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.

5. Member Signature:_____ **Date:** _____/_____/_____

IFPTE/AFSCME OPEN ENROLLMENT

INSTRUCTIONS FOR THE STATE HEALTH BENEFITS PROGRAM (SHBP) GROUP HEALTH BENEFITS ENROLLMENT and/or CHANGE FORM

SECTION 1 – EMPLOYEE INFORMATION – Complete entire section. Indicate Marital Status as follows: **S** (Single), **M** (Married), **CU** (Civil Union), **DP** (Domestic Partner), **D** (Divorced), **W** (Widowed)

SECTION 2 – EMPLOYMENT STATUS – Check one block only

SECTION 3 – HEALTH PLAN – Select only one plan. The Health Benefits *Medical Plan Design Charts* provide you with all available options. For HMO Plans only, enter the Primary Care Physician's ID#. Employees who wish to enroll in a High Deductible Health Plan (HDHP) must complete a *Health Savings Account (HSA)* form. Charts, applications, and forms can be found on our website at ***www.nj.gov/treasury/pensions***

SECTION 4 – DEPENDENT INFORMATION – List all eligible dependents currently on your health plan. Your child(ren) may be covered until the end of the calendar year they turn 26. Attach extra pages for additional dependents. You may not add dependents during this special Open Enrollment period.

SECTION 5 – MEMBER SIGNATURE – Read, sign, date, and attach required dependent documentation. Return the application to your employer's human resources office for certification.

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.

EMPLOYER CERTIFICATION – Must be completed by the Certifying Officer. The Certifying Officer's signature confirms that:

- The employee is eligible;
- The application is legible and completed in its entirety;
- The employee's selected plans and coverage levels are appropriate;
- The dependent documentation provided is complete and correct;
- The Employer Certification section is completed in its entirety; and
- The information presented is true to the best of their knowledge.

MAIL COMPLETED APPLICATION TO: **New Jersey Division of Pensions & Benefits**
P.O. Box 299
Trenton, NJ 08625-0299