HA-0889-0220

State Health Benefits Program (SHBP)

LOCAL GOVERNMENT ACTIVE EMPLOYEE GROUP

HEALTH BENEFITS ENROLLMENT AND/OR CHANGE FORM

1. MEMBER INFORMATION — Last Name | First | MI

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

Phone Number ( )

Email Address

Street Address | City | State | Zip

2. EMPLOYMENT STATUS ☐ Full Time ☐ National Guard

3. REASON FOR APPLICATION (Check one)

☐ New Enrollment ☐ Transfer
☐ Open Enrollment ☐ Loss of Coverage
☐ Adding Dependents ☐ Deleting Dependents
☐ Other

Reason_____

Date of Event _____/_____/_____

4. TYPE AND LEVEL OF COVERAGE

Level	Health	Rx
☐ Single	☐	☐
☐ Parent/Child	☐	☐
☐ Member/Spouse/Civil Union	☐	☐
☐ Member/Domestic Partner	☐	☐
☐ Family	☐	☐

DIVISION USE ONLY

Effective Dates — Event Reason:
H ____/____/____
Rx ____/____/____

EMPLOYER CERTIFICATION
(See Instructions on reverse)

Employer Name _____

Location # (State Monthly)

10/12 - month employee (Enter 10 or 12)

MEMBER ACTION

☐ New Enrollment ☐ Transfer

Date Employment Began
____/____/____

☐ Return from Leave of Absence
____/____/____

Signature of Certifying Officer

Phone Number *Date Mailed*

5. HEALTH PLAN — (Check one box only)

☐ OMNIA Health Plan ☐ NJ DIRECT/ NJ DIRECT 2019* ☐ NJ DIRECT10 ☐ NJ DIRECT15 ☐ NJ DIRECT1525
☐ NJ DIRECT2030 ☐ NJ DIRECT2035 ☐ Horizon HMO ☐ NJ DIRECT HD1500* ☐ NJ DIRECT HD4000

For HD Plans only – Health Savings Account (HSA)

☐ I wish to establish an 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 by Medicare; and
4) cannot be claimed as a dependent on another person's tax return.

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

6. DEPENDENT INFORMATION — List all eligible dependents and attach required proof of dependency documents*

☐ **Additional sheets attached. Any dependents not listed will be removed.**

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)	/ /	

***See Instructions page for detailed information and mailing address**

MEMBER 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.

7. Member Signature _____ **Date** ____/____/____