



State Health Benefits Program (SHBP) • School Employees' Health Benefits Program (SEHBP)

ACTIVE LOCAL GOVERNMENT AND LOCAL EDUCATION EMPLOYEE GROUP EMPLOYEE COVERAGE WAIVER/REINSTATEMENT FORM

PART 1: MEMBER INFORMATION

	INTERNATION STATE OF THE STATE	OHMAHON					
Last Name		First MI			DIVISION USE ONLY Effective Dates Event Reason		
							H//
Gender	Bir	th Date	Socia	d Security Number	Ī	Marital Status*	Rx//
	/	/	_	- –			EMPLOYER CERTIFICATION (See Instructions on reverse)
Phone Number			Email Address				Employer
()						Name
	·						Location # (State Monthly)
Street Ad	ddress		City	SI	tate	Zip	10/12 - month employee (Enter 10 or 12)
EMPLOYN	MENT STATUS	☐ Full Time	☐ Part Time	☐ National Guard			MEMBER ACTION
Check appropriate box(es) below.							☐ New Enrollment ☐ Existing
☐ Waiver of Coverage — I wish to waive medical and SHBP/SEHBP prescription coverage.							Date Employment Began
In accordance with P.L. 2007, c. 92 (Chapter 92) and P.L. 2010, c. 2 (Chapter 2), I have agreed to waive							
coverage (medical and SHBP/SEHBP prescription coverage) with the SHBP or SEHBP to which I am entitled because I am covered under other health coverage. I understand that I am not eligible for the Signature of Certifying Officer							
entitled because I am covered under other health coverage. I understand that I am not eligible for the waiver incentive if my other coverage is with the SHBP or SEHBP. Note: You must submit proof of the							Signature of Certifying Officer
other health coverage to your employer along with this form.							Phone Number Date Mailed
In place of health benefit coverage, my employer will pay me the amount shown in Part 2 below. I un-							
derstand that I may resume SHBP or SEHBP coverage when I am no longer covered by the other health coverage, provided that I notify the Health Benefits Bureau within 60 days of the loss of the other coverage and provide proof of loss of that coverage.							
tne Healtr	n Benefits Bur	eau witnin 60 day	s of the loss of the	e otner coverage and p	provide	proof of loss of	inat coverage.
Reins	statement of	Coverage					
I previously waived SHBP or SEHBP coverage because I had other health coverage. As of/, I am no longer covered by the							
other health plan, request reinstatement of health benefits coverage with the SHBP or SEHBP, and have provided proof of loss of the other coverage. I further understand that coverage is permitted as an employee, retiree, or dependent; however, multiple coverage under the SHBP or							
SEHBP is prohibited. Submit a Health Benefits Enrollment And/Or Change Form along with proof of loss of other coverage for all reinstatements.							
Member's	s Signature _						///////
PART 2:	EMPLOYER (CERTIFICATION					
П м _о	uill nau tha ah	ove employee \$		ovor.		in nlaa	o of providing CUDD or CELE
coverage.		nd that this payme		re than 25 percent of the	he amo	ount saved by the	e of providing SHBP or SEHE employer because of the waiv
☐ We re	equest reinstat	tement of this em	ployee's SHBP or	SEHBP coverage.			
							netable is followed, the coverage e next open enrollment period

MAIL COMPLETED APPLICATION TO:

New Jersey Division of Pensions & Benefits Health Benefits Bureau P.O. Box 299

Trenton, NJ 08625-0299