



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

Last Name		First	MI
Gender	Birth Date / /	Social Security Number - -	Marital Status*
Phone Number ()		Email Address	
Street Address		City	State Zip

DIVISION USE ONLY								
Effective Dates H ____/____/____ Rx ____/____/____	Event Reason: <input type="checkbox"/>							
EMPLOYER CERTIFICATION <i>(See Instructions on reverse)</i>								
Employer Name <u>Caldwell-West Caldwell BOE</u>								
Location # (State Monthly) <table border="1" style="width:100%; text-align: center;"> <tr> <td>1</td><td>0</td><td>6</td><td>8</td><td>-</td><td>0</td><td>0</td> </tr> </table>		1	0	6	8	-	0	0
1	0	6	8	-	0	0		
10/12 - month employee (Enter 10 or 12) <table border="1" style="width:50px; text-align: center;"> <tr> <td> </td><td> </td> </tr> </table>								
MEMBER ACTION								
<input type="checkbox"/> New Enrollment <input type="checkbox"/> Existing								
Date Employment Began ____/____/____								
_____ <i>Signature of Certifying Officer</i>								
973-228-3360 <i>Phone Number</i>	_____ <i>Date Mailed</i>							

EMPLOYMENT STATUS Full Time Part Time National Guard

Check appropriate box(es) below.

Waiver of Coverage — I wish to waive Medical Prescription Both

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, if applicable, prescription drug coverage) with the State Health Benefits Program (SHBP) or School Employees' Health Benefits Program (SEHBP) to which I am 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 other health coverage to your employer along with this form.

In place of health benefit coverage, my employer will pay me the amount shown in Part 2 below. I understand 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.

Reinstatement 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 Signature _____ Date ____/____/____

PART 2: EMPLOYER CERTIFICATION

We will pay the above employee \$ _____ every _____ in place of providing SHBP or SEHBP coverage. We understand that this payment may not be more than 25 percent of the amount saved by the employer because of the waiver or \$5,000, whichever is less.

We request reinstatement of this employee's SHBP or SEHBP coverage.

The reinstatement application must be filed within 60 days of the loss of other health coverage. If this timetable is followed, the coverage will be retroactive to the date of loss. If the 60 day time limit has passed, the employee must wait until the next open enrollment period to re-enroll.

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