HEALTH BENEFITS PROGRAM — CHAPTER 375 APPLICATION FOR SHBP/SEHBP COVERAGE OF A CHILD UP TO AGE 31

HO-0805-1011

1. COVERED CHILD'S INFORMATION-This section must be filled out completely. Please print or type.

Social Security Number ___ - ___ - ____ Last Name _____ Title (Jr., Sr., etc.) ___

First Name _____ MI ___

Street Address (Include Apartment #) **Note:** If a full-time student outside of New Jersey, attach copy of transcript.

_____

City _____ State ___ ZIP Code + 4 _____ - ____

Date of Birth (mm/dd/yy) ____ Gender (M/F) ___ (Area Code) ___ Home Telephone Number ___ - ___ - ____

Marital Status (Check One)

☐ - Single ☐ - Married / Civil Union / Domestic Partnership ☐ - Divorced / Widowed

Relationship to Employee/Retiree (Check One)

☐ - Natural Child ☐ - Adopted ☐ - Stepchild ☐ - Other (explain) _____

DIVISION USE ONLY

Effective Dates:

H _____ _____ _____

P _____ _____ _____

Location # ____ ___

Note: Eligibility under Chapter 375, P.L. 2005, is limited to a subscriber's child under the age of 31; who is unmarried; has no dependent(s) of his/her own; is a resident of New Jersey or a full-time student at an accredited public or private institution of higher education; and is not provided coverage as a subscriber, insured, enrollee, or covered person under a group or individual health benefits plan, church plan, or entitled to benefits under Medicare. Coverage is limited to the SHBP or SEHBP medical and prescription drug plans that are identical to the plans in which the parent is enrolled. The covered parent is responsible for the entire cost of coverage.

Proof of child's age and transcripts for students attending school outside of the State of New Jersey are required.

2. COVERED PARENT'S INFORMATION

Social Security Number ___ - ___ - ____

Last Name _____

First Name _____

Date of Birth (mm/dd/yy) ____

(Area Code) ___ Home Telephone Number ___ - ___ - ____

3. BILLING ADDRESS - If different from child's address

Street Address (Include Apartment #) _____

City _____

State ___ ZIP Code + 4 _____ - ____

4. CHAPTER 375 COVERAGE ELECTION

Under Chapter 375, an over age child does not have any choice in the selection of benefits but is enrolled for coverage in exactly the same plan or plans (medical and/or prescription drug) that the covered parent has selected. There is no provision for eligibility for dental or vision benefits.

☐ **I wish to be enrolled in the same plan as my parent under the provisions of Chapter 375.**

Enter the Physician ID# if enrolling in a HMO

_____

☐ **I wish to TERMINATE ALL COVERAGE under Chapter 375, P.L. 2005**

5. I CERTIFY that all the information supplied on this form is true to the best of my knowledge. I hereby make application to extend group insurance coverage under the terms Chapter 375, P.L. 2005. I authorize the Division of Pensions and Benefits to bill me for monthly premium payments and further agree to make further payments in a timely fashion. I understand this coverage will terminate without notice if payment is not made on time. I also understand that there is no guarantee of continuous participation by medical service providers, either doctors, hospitals, or other facilities in NJ DIRECT in-network coverage or the HMO plans. If my physician or medical center terminates participation in my selected plan, I must elect another doctor or medical center participating in that plan to receive the NJ DIRECT in-network or HMO 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 child as the assignee may require. I agree to notify the Health Benefits Bureau if my covered child becomes covered under another group health plan or become entitled to Medicare after electing coverage under Chapter 375, or otherwise becomes ineligible for any other reason (see Note above).

Misrepresentation: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties.

_____ _____

SHBP/SEHBP Covered Parent's Signature Date Completed

_____ _____

Covered Child's Signature Date Completed

DO NOT SEND PAYMENT WITH APPLICATION — YOU WILL BE BILLED

COMPLETING THE CHAPTER 375 APPLICATION FOR COVERAGE OF OVER AGE CHILD UP TO AGE 31

STATE HEALTH BENEFITS PROGRAM
SCHOOL EMPLOYEES' HEALTH BENEFITS PROGRAM

Under the provisions of Chapter 375, P.L. 2005, certain over age children may be eligible for coverage under the State Health Benefits Program (SHBP) or School Employees' Health Benefits Program (SEHBP) until age 31. This includes a subscriber's child by blood or law who: is under the age of 31 (a copy of the Birth Certificate is required); unmarried; has no dependent(s) of his or her own; is a resident of New Jersey or is a full-time student at an accredited public or private institution of higher education; and is not provided coverage as a subscriber, insured, enrollee, or covered person under a group or individual health benefits plan, church plan, or entitled to benefits under Medicare. An over age child is eligible for coverage in the SHBP or SEHBP medical and prescription drug plans that are identical to the plans in which the covered parent is enrolled. The covered parent is responsible for the entire cost of coverage (see Section 3 below for details).

SECTION 1 — COVERED CHILD'S INFORMATION

This section pertains to the child enrolling in the Chapter 375 coverage. Complete all requested information, filling in one letter or number per block. Provide month, day, and year for Date of Birth (for example: April 12, 1980 = 04 12 80). If child is a full-time student, attach copy of the transcript from the accredited public or private institution of higher education. Please be certain to indicate the specific relationship to the covered parent (natural child, adopted, stepchild, etc.).

SECTION 2 — COVERED PARENT'S INFORMATION

This section pertains to the covered parent under whom regular SHBP or SEHBP dependent child coverage eligibility has ended. Complete all requested information, filling in one letter or number per block. Provide month, day, and year for Date of Birth (for example: March 22, 1957 = 03 22 57). Please also include a home telephone number for the covered parent.

SECTION 3 — BILLING ADDRESS

List the complete mailing address where the Health Benefits Bureau should send the monthly bill for Chapter 375 premium payment. The covered parent is responsible for the entire cost of coverage. When Chapter 375 coverage is elected, the covered parent will be billed directly by the SHBP for the cost of the coverage. Chapter 375 rates for all SHBP and SEHBP plans are available over the Internet at: *www.state.nj.us/treasury/pensions/health-benefits.shtml*

SECTION 4 — COVERAGE ELECTION

Check the appropriate box(es):

- Indicate that you wish to enroll for Chapter 375 coverage. You must indicate the same plan inwhich the covered parent is enrolled. If you select an HMO you must also list the identification number of the child's Primary Care Physician. Prescription drug coverage, if provided through the SHBP or SEHBP, will be the same as the covered parent's prescription drug enrollment; or
- Indicate that you wish to terminate all coverage under Chapter 375.

SECTION 5 — CERTIFICATION AND SIGNATURE

Both the Chapter 375 covered child and the covered parent must read the certification and sign and date the application.

Misrepresentation: Any person who provides false or misleading information is subject to criminal and civil penalties.

Return this application and all supporting documentation to:

NJ DIVISION OF PENSIONS AND BENEFITS
HEALTH BENEFITS BUREAU
P.O. BOX 299
TRENTON, NJ 08625-0299

DOCUMENTATION REQUIRED FOR SHBP/SEHBP DEPENDENT ELIGIBILITY AND ENROLLMENT
FOR COVERAGE UNDER CHAPTER 375, P.L. 2005

Chapter 375, P.L. 2005, requires that only eligible over age dependent children receive health care coverage under the State Health Benefits Program (SHBP) or School Employees' Health Benefits Program (SEHBP). As a result, the Division of Pensions and Benefits requires the following documentation in addition to the *Chapter 375 Enrollment Application* when enrolling an over age dependent child.

DEPENDENTS	CHAPTER 375 ELIGIBILITY DEFINITION	DOCUMENTATION REQUIRED
CHILDREN UNTIL AGE 26	A subscriber's child until age 26, *regardless* of the child's marital, student, or financial dependency status – even if the young adult no longer lives with his or her parents. This includes a stepchild, foster child, legally adopted child, or any child in a guardian-ward relationship upon submitting required supporting documentation.	**Natural or Adopted Child** – A photocopy of the child's birth certificate — or a photocopy of a National Medical Support Notice (NMSN) if you are the non-custodial parent and are legally required to provide coverage for the child — showing the name of the employee/retiree as a parent. **Step Child** – A photocopy of the child's birth certificate showing the name of the employee/retiree's spouse or partner as a parent **and** a photocopy of the marriage/partnership certificate showing the names of the employee/retiree and spouse/partner. **Legal Guardian, Grandchild, or Foster Child** – Photocopies of Final Court Orders with the presiding judge's signature and seal. Documents must attest to the legal guardianship by the covered employee.
CONTINUED COVERAGE FOR OVER AGE CHILDREN UNTIL AGE 31	Certain children over age 26 may be eligible for continued coverage until age 31 under the provisions of Chapter 375, P.L. 2005. This includes a child by blood or law who: **(1)** is under the age of 31; **(2)** is unmarried or not a partner in a civil union or domestic partnership; **(3)** has no dependent(s) of his or her own; **(4)** is a resident of New Jersey or is a student at an accredited public or private institution of higher education with at least 15 credit hours; and **(5)** is not provided coverage as a subscriber, insured, enrollee, or covered person under a group or individual health benefits plan, church plan, or entitled to benefits under Medicare.	Documentation for the appropriate "Child" type (as noted above) **and** a photocopy of the front page of the child's most recently filed federal tax return* (*Form 1040*), **and** if the child resides outside of the State of New Jersey, documentation of full time student status must be submitted.

***Note:** *On tax forms you may black out all financial information and all but the last 4 digits of any Social Security numbers.*

To obtain copies of the documentation listed above, contact the office of the Town Clerk in the city of birth, marriage, etc., or visit these Web sites: ***www.vitalrec.com*** or ***www.studentclearinghouse.org*** Residents of New Jersey can obtain records from the State Bureau of Vital Statistics and Registration Web site: ***www.state.nj.us/health/vital/index.shtml***