HB-0840-0913

# REQUIRED DOCUMENTATION FOR SHBP/SEHBP DEPENDENT ELIGIBILITY AND ENROLLMENT

The State Health Benefits Program (SHBP) and School Employees' Health Benefits Program (SEHBP) are required to ensure that only employees, retirees, eligible children, and eligible dependents are receiving health care coverage under the programs. As a result, the Division of Pensions and Benefits must guarantee consistent application of eligibility requirements within the plans. Employees or Retirees who enroll children or dependents for coverage (spouses, civil union partners, domestic partners, children, disabled and/or over age children continuing coverage) must submit the following documentation in addition to the appropriate health benefits enrollment or change of status application.

| DEPENDENTS | ELIGIBILITY DEFINITION | DOCUMENTATION REQUIRED |
|---|---|---|
| **SPOUSE** | A person of the opposite sex or same sex to whom you are legally married. | A photocopy of the *Marriage Certificate* **and** a photocopy of the front page of the employee/retiree's most recently filed federal tax return* (*Form 1040*) that includes the spouse. |
| **CIVIL UNION PARTNER** | A person of the same sex with whom you have entered into a civil union. | A photocopy of the *New Jersey Civil Union Certificate* or a valid certification from another jurisdiction that recognizes same-sex civil unions **and** a photocopy of the front page of the employee/retiree's most recently filed New Jersey tax return* that includes the partner **or** a photocopy of a recent (within 90 days of application) bank statement or bill that includes the names of both partners and is received at the same address. |
| **DOMESTIC PARTNER** | A person of the same sex with whom you have entered into a domestic partnership. Under Chapter 246, P.L. 2003, the Domestic Partnership Act, health benefits coverage is available to domestic partners of State employees, State retirees, or employees or retirees of a SHBP or SEHBP participating local public entity that has adopted a resolution to provide Chapter 246 health benefits. | A photocopy of the *New Jersey Certificate of Domestic Partnership* dated prior to February 19, 2007 or a valid certification from another State of foreign jurisdiction that recognizes same-sex domestic partners **and** a photocopy of the front page of the employee/ retiree's most recently filed New Jersey tax return* that includes the partner **or** a photocopy of a recent (within 90 days of application) bank statement or bill that includes the names of both partners and is received at the same address. |
| **CHILDREN** | 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.<br>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 showing the name of the employee/retiree as a parent.<br>**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.<br>**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. |
| **DEPENDENT CHILDREN WITH DISABILITIES** | If a covered child is not capable of self-support when he or she reaches age 26 due to mental illness or incapacity, or a physical disability, the child may be eligible for a continuance of coverage. Coverage for children with disabilities may continue only while (1) you are covered through the SHBP/SEHBP, and (2) the child continues to be disabled, and (3) the child is unmarried or does not enter into a civil union or domestic partnership, and (4) the child remains substantially dependent on you for support and maintenance. You may be contacted periodically to verify that the child remains eligible for coverage. | Documentation for the appropriate "Child" type (as noted above) **and** a photocopy of the front page of the employee/retiree's most recently filed federal tax return* (*Form 1040*) that includes the child.<br>If Social Security disability has been awarded, or is currently pending, please include this information with the documentation that is submitted.<br>**Please note** that this information is only verifying the child's eligibility as a dependent. The disability status of the child is determined through a separate process. |
| **CONTINUED COVERAGE FOR OVER AGE CHILDREN** | 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:*** *For 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 documents listed above, contact the office of the Town Clerk in the city of the 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***

# GROUP ENROLLMENT/CHANGE REQUEST

**Upon completion this form should be submitted to the EHT Schools Business Office located at the Slaybaugh Primary School Administrative Offices along with the required documentation.**

**Group Name**: EGG HARBOR TOWNSHIP BOARD EDUCATION

*This space to be completed by the employer:* *Group#0851J5*
*Group#08505K*

**Section A:** Employee to complete

- ☐ Single
- ☐ Parent/Child(ren)
- ☐ 2Adults
- ☐ Family

**Section B:** Employee to complete

- ☐ Direct Access Educators Plan (sub group 40)
- ☐ Direct Access Garden State Health Plan (sub group 45)

**Plan designs and costs are located at the district's website: www.eht.k12.nj.us under employee benefits.**

**Section C**: Employee Information

Employee Name: _____
*Last* *First* *M*

Address: _____
*Mailing Address* *City,* *State* *Zip Code*

Social Security #: _____ Date of Birth: _____

Phone #: _____*cell or home* Date of Hire: _____

☐ *Male or* ☐ *Female* ☐ *Single* ☐ *Married* ☐ *Civil Union* ☐ *Domestic Partner* ☐ *Divorced* ☐ *Widowed*

**Section D**: Spouse/Civil Union/Domestic Partner and Dependent Information

*Spouse/CU/DP Name _____
*Last* *First* *M*

Social Security #_____ Date of Birth: _____ Gender M/F ☐

**Child Name _____
*Last* *First* *M*

Social Security #_____ Date of Birth: _____ Gender M/F ☐

**Child Name _____
*Last* *First* *M*

Social Security #_____ Date of Birth: _____ Gender M/F ☐

**Child Name _____
*Last* *First* *M*

Social Security #_____ Date of Birth: _____ Gender M/F ☐

**Child Name _____
*Last* *First* *M*

Social Security #_____ Date of Birth: _____ Gender M/F ☐

**Section E**: Type of Activity-

Enrollment: ☐ New Hire ☐ Return from Leave ☐ Loss of coverage ☐ Other _____

Change: ☐ Add Spouse/Civil Union/Domestic Partner Date of event: _____

Add Dependent: ☐ Birth ☐ Adoption ☐ Loss of coverage Date of event: _____

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Change: ☐ Remove Spouse/Civil Union/Domestic Partner Date of Event: _____

☐ Divorce ☐ Term of DP ☐ Dissolution of CU ☐ Death

Address of ex-spouse/ex-partner: _____

*(this address will be used to mail the offer of COBRA benefits, as required by law)*

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Change: ☐ Remove Child SS# _____ Reason: _____

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Other Changes: ☐ Name Change Former Name _____ ☐ Change of Address

☐ Switch Plan From _____ To _____

☐ Other (Not Listed) _____

☐ Terminate Coverage

*Instructions:*

- *Any time you submit this form it must include each dependent who you wish to remain on your medical insurance. Omission of your spouse or children will result in their removal from the plan.*
- *Please print, except for when a signature is requested*
- *If you are adding a spouse, civil union or domestic partner you must submit a copy of the certificate*
- *If you are enrolling with a spouse you must include a copy of the front page of your most recently filed Federal Tax Form (Form 1040) that includes your spouse. You may black out/white out the financial information (unless your were recently married)*
- *If you are adding a child you must submit a copy of the birth certificate, adoption order or court order of custody or guardianship. Birth certificates must list parent's names. If they do not, you must obtain an updated copy.*
- *If you are removing a spouse/CU/DP you must provide documentation from the court and supply a new address so that the district can offer that person COBRA benefits*
- *If your dependent is disabled and you would like to continue coverage beyond age 26, please contact the office*

I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth by the EHT BOE. I authorize deductions from my earnings for any contributions required from me.

Employee
Signature: _____ Date: _____/_____/_____

The requested activity is believed eligible and is approved by the Employer.

Employer Representative: _____ Date: _____/_____/_____

Representative's Title: _____

Rules:

**Benefits Start Date**: **a)** 10 month employee beginning work on 9/1, benefits start 9/1 **b)** Begin work on the 1st of the month, start date is in one month **c)** any other situation- using start date, to the 1st of the month plus one month
**Benefits Ending Date**: **a)** Last paid date, to the 1st of the month plus one month **b)** Last paid date is 1st of month, end date is one month **c)** 10 month employee who worked the entire school will maintain benefits through 9/1 **d)** Death of employee, benefits for spouse/dependents end the 1st of the month following date of death **e)** Divorce- spouse is removed on the 1st of the month following the court date

BeneCard PBF
Prescription Benefit Facilitator

# Enrollment Form

TODAY'S DATE:

## CLIENT INFORMATION

Egg Harbor Township Board of Education

CLIENT NAME (PLAN SPONSOR / EMPLOYER) | CLIENT # | GROUP #

## CARDMEMBER INFORMATION

FIRST NAME | MI | LAST NAME | ID # | SSN#

MAILING ADDRESS | CITY | STATE | ZIP CODE

PHONE NUMBER | CELL PHONE | EMAIL

## COVERAGE TYPE

PLEASE CHECK ONE:

☐ SINGLE ☐ CARDMEMBER/SPOUSE ☐ CARDMEMBER/CHILD ☐ CARDMEMBER/CHILDREN ☐ FAMILY

EFFECTIVE DATE:

## REASON CODE

| | |
|---|---|
| A | NEW ENROLLMENT |
| B | REINSTATE MEMBER |
| C | REINSTATE DEPENDENT / SPOUSE |
| D | ADD DEPENDENT / SPOUSE |
| E | TERMINATE COVERAGE |
| F | TERMINATE DEPENDENT COVERAGE |
| G | NAME CHANGE |
| H | ADDRESS CHANGE |
| I | GROUP CHANGE: FROM_____ TO _____ |

| | |
|---|---|
| J | RDS ENROLLMENT, APPLICATION NUMBER IF APPLICABLE: _____ |
| K | ISSUE CARD |
| L | DO NOT ISSUE ID CARD |
| M | COBRA ENROLLMENT |
| N | COBRA TERMINATION |
| O | STUDENT STATUS UPDATE |
| P | DISABLED DEPENDENT |
| Q | OVERAGE DEPENDENT** |
| R | DEPENDENT ADDRESS DIFFERS FROM CARDMEMBER (INCLUDE ON BACK) |

## ELIGIBILITY

| | LAST NAME | FIRST NAME | MI | GENDER | BIRTHDATE | SSN | HICN | REASON CODES |
|---|---|---|---|---|---|---|---|---|
| CARDMEMBER | | | | | | | | |
| 02 SPOUSE | | | | | | | | |
| EMAIL/PHONE* | | | | | | | | |
| 03 DEPENDENT | | | | | | | | |
| EMAIL/PHONE* | | | | | | | | |
| 04 DEPENDENT | | | | | | | | |
| EMAIL/PHONE* | | | | | | | | |
| 05 DEPENDENT | | | | | | | | |
| EMAIL/PHONE* | | | | | | | | |
| 06 DEPENDENT | | | | | | | | |
| EMAIL/PHONE* | | | | | | | | |
| 07 DEPENDENT | | | | | | | | |
| EMAIL/PHONE* | | | | | | | | |
| 08 DEPENDENT | | | | | | | | |
| EMAIL/PHONE* | | | | | | | | |

*OPTIONAL, ONLY IF DIFFERENT FROM CARMEMBER

## COORDINATION OF BENEFITS

SECONDARY COVERAGE ID NUMBER | INSURANCE COMPANY | POLICY / GROUP#

EMPLOYER/PLAN SPONSOR | EFFECTIVE DATE

## SIGNATURES

MEMBER SIGNATURE | CLIENT SIGNATURE

**FOR INTERNAL USE ONLY:**

DATE ENTERED:_____ ENTERED BY:_____ LOGGED BY:_____

3131 Princeton Pike, Bldg. 2B, Suite 103, Lawrenceville, NJ 08648 Fax: 609-219-1660 eligibility@benecard.com www.benecardpbf.com

## Dependent Address (1)
(if differs from cardmember)

# Back of Enrollment Form

FIRST NAME | MI | LAST NAME | ID # | SSN

MAILING ADDRESS | CITY | STATE | ZIP CODE

PHONE NUMBER | CELL PHONE | EMAIL

## Dependent Address (2)
(if differs from cardmember)

FIRST NAME | MI | LAST NAME | ID # | SSN

MAILING ADDRESS | CITY | STATE | ZIP CODE

PHONE NUMBER | CELL PHONE | EMAIL

## Dependent Address (3)
(if differs from cardmember)

FIRST NAME | MI | LAST NAME | ID # | SSN

MAILING ADDRESS | CITY | STATE | ZIP CODE

PHONE NUMBER | CELL PHONE | EMAIL

## Dependent Address (4)
(if differs from cardmember)

FIRST NAME | MI | LAST NAME | ID # | SSN

MAILING ADDRESS | CITY | STATE | ZIP CODE

PHONE NUMBER | CELL PHONE | EMAIL

## Dependent Address (5)
(if differs from cardmember)

FIRST NAME | MI | LAST NAME | ID # | SSN

MAILING ADDRESS | CITY | STATE | ZIP CODE

PHONE NUMBER | CELL PHONE | EMAIL

Delta Dental

Delta Dental of New Jersey
P.O. Box 23700, Newark, NJ 07189-0001
(973) 285-4144

# Dental Enrollment/Change Form

| **Egg Harbor Township Board of Education** | **Effective date of Coverage** | **Delta Dental Premier Plan Group #7131-0105** |
|---|---|---|

## General Information- This section must be completed- Please print clearly

| **Name (Last, First, MI)** | **Date of Birth** | **Social Security Number** |
|---|---|---|
| | | |

| **Address (number, street, city, state, zip code)** | | | |
|---|---|---|---|
| | | | |

| **Date of Employment** | **____ Single** **____ Parent/child**<br>**____ Husband/wife** **____ Parent/children**<br>**____ Family** | **___ Single**<br>**___ Married**<br>**___ Divorced** | **Home Telephone Number** |
|---|---|---|---|
| | | | |

| | **Name (First, MI, Last)** | **A-add R-remove C-change** | **Date of Birth** | **Social Security Number** |
|---|---|---|---|---|
| **Employee** | | | | |
| **Spouse** | | | | |
| **Dependent** | | | | |
| **Dependent** | | | | |
| **Dependent** | | | | |
| **Dependent** | | | | |
| **Dependent** | | | | |

I understand that any changes to my dependent status must be reported to my employer. I understand that children are covered until the end of the year in which they turn 23 years of age, provided they are dependent upon me for maintenance and support, are not married and do not have coverage of their own. If a dependent is a step-child or legal ward, I understand that I must complete an *Affidavit of Dependency* as available in my employer's human resource office. I hereby represent that all information furnished is true and complete to the best of my knowledge and authorize my employer to make any required deduction from my wages.

Employee Signature _____ Date _____

# Egg Harbor Township Board of Education

Benefits Office
13 Swift Drive
Egg Harbor Township, NJ 08234
609-646-7911 x1023
halkam@eht.k12.nj.us

**Adding a Dependent**

Horizon Enrollment Form
Complete section A and B indicating your plan and your level of coverage
Complete section C with your new information
Complete section D by **listing each dependent who is to be covered on your benefits**
Complete section E by choosing Add Dependent
*If you have more than four children to add, please use a second copy of this page.*
Please sign

Include the birth certificate, which must include parents' names, of child being added.

Benecard
Complete Cardmember Information
Complete Coverage Type
Complete Eligibility with Each Dependent to be covered. Use Reason Code D for the dependent to be added.
Please sign

Delta Dental
Complete General Information
List each Dependent to be covered. Use Reason Code A for the dependent to be added.
Please sign

**Marriage**

Horizon Enrollment Form
Complete section A and B indicating your coverage and your level of coverage
Complete section C with your new information
Complete section D by **listing each dependent who is to be covered on your benefits**
Section E: Add your spouse
Please sign

A copy of your most recently filed federal 1040 form is required (you can black out or white out any financials).
A copy of your marriage certificate is required.
If you added any children 26 or under, you must provide a copy of each child's birth certificate.
*If you have more than four children to add, please use a second copy of this page.*

# Egg Harbor Township Board of Education

Benefits Office
13 Swift Drive
Egg Harbor Township, NJ 08234
609-646-7911 x1023
halkam@eht.k12.nj.us

Benecard
Complete Cardmember Information
Complete Coverage Type
Complete Eligibility with Each Dependent to be covered. Use Reason Code D for the dependent to be added.
Please sign

Delta Dental
Complete General Information
List each Dependent to be covered. Use Reason Code A for the dependents to be added.
Please sign

**Remove Dependent**
Horizon Enrollment Form
Complete section A and B indicating your coverage and your level of coverage
Complete section C with your new information
Complete section D by **listing each dependent who is to be covered on your benefits**
Complete section E by listing the dependent you would like to remove
Please sign

Benecard
Complete Cardmember Information
Complete Coverage Type
Complete Eligibility with Each Dependent to be covered. Use Reason Code F for the dependent to be removed.
Please sign

Delta Dental
Complete General Information
List each Dependent. Use Reason Code R for the dependents to be removed
Please sign