HA-0109-0607p

STATE OF NEW JERSEY
DEPARTMENT OF THE TREASURY
DIVISION OF PENSIONS AND BENEFITS
PO BOX 299
TRENTON, NJ 08625-0299

STATE HEALTH BENEFITS PROGRAM COVERAGE LOCAL GOVERNMENT/EDUCATIONAL EMPLOYEE WAIVER/REINSTATEMENT

Part 1: To be completed by the employee. Please print.

1. Name _____ SS# _____

Check one box below.

☐ **Waiver of Coverage**
In accordance with Chapter 92, P.L. 2007, I have agreed to waive the State Health Benefits Program (SHBP) coverage to which I am entitled because I am covered under other health coverage.

In place of health benefit coverage, my employer will pay me the amount shown in Part 2 below. I understand that I may resume State Health Benefits Program coverage when I am no longer covered by the other health coverage, provided that I notify the SHBP within 60 days of the loss of the other coverage and provide proof of loss of that coverage.

☐ **Reinstatement of Coverage**
I previously waived State Health Benefits Program coverage because I had other health coverage.
As of _____, I am no longer covered by the other health plan, request reinstatement of the State
(date)
Health Benefits Program coverage, and have provided proof of loss of the other coverage.

Employee's Signature _____ **Date** _____

Part 2: To be completed by the employer. Check one box below.

☐ We will pay the above employee $_____ every _____ in place of providing State Health Benefits Program coverage. We understand that this payment may not be more than 50% of the amount saved by the employer because of the voluntary waiver.

☐ We request reinstatement of this employee's State Health Benefits Program coverage.

A completed *State Health Benefits Program Application* must be attached to either a waiver or a reinstatement. If the application for waiver is received by the Health Benefits Bureau by the 5th of the month, the change will take place on the first of the following month. 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 reenroll.

Employer Name _____ SHBP Location # _____

Signature of Certifying Officer _____ Date _____