HA-0109-0510p

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

COVERAGE WAIVER/REINSTATEMENT FOR LOCAL GOVERNMENT/EDUCATIONAL EMPLOYEES

STATE HEALTH BENEFITS PROGRAM
SCHOOL EMPLOYEES' HEALTH BENEFITS PROGRAM

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 and Chapter 2, P.L. 2010, 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
(date)
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.

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 or School Employees' Health Benefits Program coverage. We understand that this payment may not be more than 25% of the amount saved by the employer because of the waiver **or** $5,000, whichever is less.

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

A completed *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/SEHBP Location # _____

Signature of Certifying Officer _____ Date _____