HC-0807-0514

— COBRA NOTICE —
CONTINUATION OF HEALTH BENEFITS COVERAGE UNDER COBRA
FOR PART-TIME EMPLOYEES ELIGIBLE UNDER CHAPTER 172, P.L. 2003
SCHOOL EMPLOYEES' HEALTH BENEFITS PROGRAM

This page is to be completed by Employer

(Please print or type)

To the Family of —

_____

_____

_____

_____

SS#: _____

Notice Date: _____

Employer Name: _____

Emp ID #: _____

EMPLOYEE TYPE:

☐ 10 month

☐ 12 month

Dear Employee and/or Dependent(s):

Your health care coverage under the State Health Benefits Program (SHBP) or School Employees' Health Benefits Program (SEHBP) terminates as shown below because of a change in employment status or dependent eligibility. The reason for the loss of coverage, the type(s) of coverage lost and the last day of coverage(s) are shown in the notice below. Under the provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you are entitled to continue your medical benefits with the group program for a limited time.

If you wish to continue coverage under the provisions of COBRA, you must enroll at this time. Otherwise, you will lose coverage and you cannot enroll later.

Please Note: Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at *www.healthcare.gov.*

You may continue the group coverage(s) shown below under COBRA, at your own expense, for the time period shown in the COBRA Continuation Term or until one of the following conditions occur: (1) you voluntarily cancel your coverage; (2) you become covered under MEDICARE or another group plan after you elect COBRA coverage (Note: Exceptions are made if your other group has a pre-existing condition clause that affects you); (3) you fail to pay your premiums in a timely manner; or (4) your employer drops out of the SEHBP.

In considering whether to elect continuation of coverage under COBRA, you should take into account that you cannot enroll at a later date and that a failure to continue your group health coverage may affect your future rights under federal law. Please refer to Fact Sheet #30, *Continuation of Coverage Under COBRA,* for more information on your election of COBRA coverage.

If you wish to continue your group coverage under the provisions of COBRA, complete the application on the reverse side and send it to the **Division of Pensions and Benefits, P.O. Box 299, Trenton, NJ, 08625-0299**. If you elect to continue coverage, you will be enrolled retroactive to the date you lost coverage. After your application is processed (allow up to three weeks), you will be sent a letter of confirmation of enrollment indicating the beginning date(s) of your COBRA coverage(s) and the length of your COBRA eligibility. The Health Benefits Bureau will send you an invoice of premiums that are due for your coverage (including retroactive premium due).

You should make a copy of this notice and your completed application for your records prior to mailing the application **and** any required proof of dependency documentation to the Division of Pensions and Benefits. After mailing, if you do not receive the confirmation of enrollment identified in the preceding paragraph, you should contact the Division of Pensions and Benefits' Office of Client Services at (609) 292-7524 or by e-mail at *pensions.nj@treas.state.nj.us*

COBRA EVENT: (check one)

- ☐ Termination: Involuntary
- ☐ Termination: Gross Misconduct
- ☐ Termination: Voluntary, Other
- ☐ Death
- ☐ Divorce or Separation/Dissolution of Civil Union or Domestic Partnership
- ☐ Dependent Ineligibility Over Age 26
- ☐ Medicare Entitlement

CURRENT COVERAGE TYPE: (check one)	
Medical Plan: _____ (Indicate Plan Name)	**PRESCRIPTION DRUG PLAN**
☐ Single	☐ Single
☐ Member & Spouse/Civil Union Partner	☐ Member & Spouse/Civil Union Partner
☐ Member & Domestic Partner	☐ Member & Domestic Partner
☐ Parent & Child(ren)	☐ Parent & Child(ren)
☐ Family	☐ Family

DATE OF COBRA EVENT: _____

CONTINUATION TERM: _____ months of COBRA eligibility.

LAST DATE OF COVERAGE (Month/Date/Year): Medical _____ Rx _____

EMPLOYER CONTACT AND TELEPHONE #: _____

_____

Signature of Certifying Officer

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE OR THE LAST DATE OF COVERAGE, WHICHEVER IS LATER, TO ELECT COVERAGE UNDER COBRA. FAILURE TO RESPOND WITHIN THIS TIME PERIOD IS CONSIDERED A DECISION NOT TO CONTINUE COVERAGE.

HEALTH BENEFITS PROGRAM COBRA APPLICATION - SEHBP PART-TIME GROUP

HC-0807-0915

1 APPLICANT INFORMATION -This section must be filled out completely. Please print or type.

Applicant's Social Security Number

___ - ___ - ____

Last Name | Title (Jr., Sr., etc.)

First Name | MI

Street Address (Include Apartment #)

City | State

ZIP Code + 4 | Date of Birth (mm/dd/yy) | Gender (M/F)

Status:

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

(Area Code) Home Telephone Number

___ - ___ - ____

Are you transferring your health benefits from another SHBP/SEHBP participating employer?

☐ No ☐ Yes If yes, list name of employer: _____

2A. MEDICAL COVERAGE (Check one box only).

HORIZON	AETNA
☐ NJ DIRECT15	☐ Aetna Freedom15
☐ NJ DIRECT10	☐ Aetna Freedom10
☐ NJ DIRECT1525	☐ Aetna Freedom1525
☐ NJ DIRECT2030	☐ Aetna Freedom2030
☐ NJ DIRECT2035	☐ Aetna Freedom2035
☐ Horizon HMO	☐ Aetna HMO
☐ Horizon HMO1525	☐ Aetna HMO1525
☐ Horizon HMO2030	☐ Aetna HMO2030
☐ Horizon HMO2030	☐ Aetna HMO2030

For HMOPlans, Enter Primary Care Physician's ID#:

_____

2B. LEVEL OF COVERAGE (Check one box)

☐ Single ☐ Member & Spouse/Civil Union Partner *(see instructions)*

☐ Family ☐ Parent/Child(ren)

☐ Member & Domestic Partner *(see instructions)*

3. PRESCRIPTION DRUG COVERAGE

LEVEL OF PRESCRIPTION DRUG PLAN COVERAGE

☐ Single ☐ Member and Spouse/Civil Union Partner

☐ Member and Domestic Partner (see instructions)

☐ Family ☐ Parent and Children

4. CHANGE INFORMATION (if applicable)

Type:

☐ Open Enrollment

☐ Special Enrollment

☐ Status Change (Indicate reason below)

Moved Out of Coverage Area
(Date of Move) _____

Add Spouse (Date of Event) _____
(Attach Marriage Certificate)

Add Civil Union/Domestic Partner (Date of Event) _____
(Attach Civil Union or Domestic Partnership Certificate — see note at right)

Add Dependent Child

☐ Birth

☐ Adoption/Guardianship (Date of Event) _____
(Proof Required)

Other (Specify) _____

5. EMPLOYEE INFORMATION (if different from applicant)

Last Name

First Name

Social Security Number

___ - ___ - ____

Date of Birth (mm/dd/yy)

DIVISION USE ONLY

Effective Dates: Event Reason:

H _____ _____ _____

P _____ _____ _____

Location # | Term (mos) 7 0

Spouse is a person of the opposite sex or same sex to whom you are legally married. A photocopy of the *Marriage Certificate* and most recent federal tax return that includes the spouse are required for enrollment (see requirements page).

Civil Union Partner is a person of the same sex with whom you have entered into a civil union. A photocopy of the *Civil Union Certificate* and most recent NJ tax return that includes the partner are required for enrollment (see requirements page).

Domestic Partner is a same-sex domestic partner, as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act. A photocopy of the *Certificate of Domestic Partnership* and most recent NJ tax return that includes the partner are required for enrollment. A local government/education employer must elect to provide domestic partner health benefits coverage (see requirements page).

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

6. DEPENDENT INFORMATION - List all eligible dependents you wish to enroll for coverage and attach required proof of dependency documents (see requirements page). Use a separate page for additional dependents.

☐ Spouse/Civil Union/Domestic Partner	Last Name	First Name	MI	Date of Birth (mm/dd/yy)	Gender (M/F)	Social Security Number	Natural (C) Adopted (A) Foster (F) Step (S) Legal Ward (L) See Instructions
Children							

7. ☐ **SSA DISABILITY EXTENSION** — Check this box if you have an approved Social Security Administration Disability and wish your COBRA term extended to up to 29 months. Attach a copy of the Social Security Administration Disability approval letter.

8. I certify that all the information supplied on this form is true to the best of my knowledge. I hereby make application to extend my group insurance coverage under the terms of the program. I understand that my coverage under COBRA will be continuous from the date benefits end. 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 COBRA coverage will terminate without notice if payment is not made on time. I understand that if I waive my right to coverage at this time, enrollment is not normally permissible at a later date. I also understand that there is no guarantee of continuous in-network participation by medical service providers, either doctors or facilities in the NJ DIRECT15 plan. If either my physician or medical center terminates participation, I must elect another doctor or medical center participating in NJ DIRECT15 to receive the in-network 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 dependents as the assignee may require. I agree to notify the COBRA Administrator if I or any of my covered dependents become covered under another group health plan or become entitled to Medicare after I elect coverage under COBRA.
Misrepresentation: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties.

Applicant's Signature _____ Date Completed _____

DO NOT SEND PAYMENT WITH APPLICATION — YOU WILL BE BILLED