



TO: EMPLOYEES WITH NEW JERSEY STATE HEALTH BENEFITS AND PENSION
FROM: HUMAN RESOURCES
RE: CHANGE OF NAME

All employees with health benefits and pension that require a change of name must complete the attached forms:

- ***State New Jersey Affidavit Change of Name***
- ***State of New Jersey Health Benefits Application***

Please submit the completed forms with a copy of your ***New Social Security Card*** to Human Resources Linden Hall for processing.

Thank You

STATE OF NEW JERSEY
Department of the Treasury — Division of Pensions and Benefits
PO Box 295, Trenton, New Jersey 08625-0295

AFFIDAVIT — CHANGE OF NAME

Retirement System: Public Employees' Retirement System Teachers' Pension and Annuity Fund
 State Police Retirement System Police and Firemen's Retirement System Other

1. Previous Name _____

2. Membership Number _____ 3. Social Security Number _____

4. Change the records of the Division of Pensions and Benefits
to reflect my name as _____

5. Reason for Name Change _____

6. My signature as previously written was _____

7. My signature as it will be in the future is _____

8. My present address is _____
(Street)

(City, State, Zip Code)

(Area Code) (Phone Number)

(Your Signature)

State of _____

County of _____

Sworn and subscribed
before me this _____ day of _____, _____

Signature of Notary or
Commissioner of Deeds _____

My Commission expires _____ / _____ / _____

Official Title _____

1. EMPLOYEE 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 #)

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: _____

2. MEDICAL COVERAGE

2a. EMPLOYEE SELECTION (Choose only one plan)

HORIZON	AETNA	CIGNA
<input type="checkbox"/> NJ DIRECT15	<input type="checkbox"/> Aetna HMO	<input type="checkbox"/> CIGNA HMO
<input type="checkbox"/> NJ DIRECT1525	<input type="checkbox"/> Aetna1525	<input type="checkbox"/> CIGNA1525
<input type="checkbox"/> NJ DIRECT2030	<input type="checkbox"/> Aetna2030	<input type="checkbox"/> CIGNA2030
<input type="checkbox"/> NJ DIRECT HD4000	<input type="checkbox"/> Aetna HD4000	<input type="checkbox"/> CIGNA HD4000
<input type="checkbox"/> NJ DIRECT HD1500	<input type="checkbox"/> Aetna HD1500	<input type="checkbox"/> CIGNA HD1500

For Aetna or CIGNA Plans, enter Primary Care Physician's ID#

I elect to waive medical coverage in any medical plan (see instructions).*

2b. LEVEL OF COVERAGE

Single Member and Spouse/Civil Union Partner
 Member and Domestic Partner (see instructions)
 Family Parent and Child(ren)

3. PRESCRIPTION DRUG COVERAGE

3a. EMPLOYEE SELECTION

I wish to be covered by the Employee Prescription Drug Plan.
 I elect to waive Employee Prescription Drug Plan coverage.*

3b. LEVEL OF COVERAGE

Single Member and Spouse/Civil Union Partner
 Member and Domestic Partner (see instructions)
 Family Parent and Child(ren)

Employees who choose a high deductible (HD) health plan cannot enroll in another prescription drug plan. Prescription drug benefits will be provided in conjunction with the medical plan. **Do not complete this section if you chose a high deductible (HD) health plan.**

*Both Medical and Prescription Drug coverage must be waived to avoid paying a contribution.

DIVISION USE ONLY

Effective Dates: _____ Event Reason: _____

H

P

EMPLOYER CERTIFICATION
See instructions on reverse

Employer Name: _____

Payroll # (State Biweekly) Union Code (Rx) Only

Location # (State Monthly)

10/12 month employee (Enter "10" or "12")

MEMBER ACTION

New Enrollment Transfer
 Date Employment Began _____ (mm/dd/yy)

Return from Leave of Absence _____ (mm/dd/yy)

 Signature of Certifying Officer

Telephone # _____ Date Mailed _____

4. DEPENDENT INFORMATION - List only eligible dependents and attach required proof of dependency documents (see instructions on reverse).

<input type="checkbox"/> Spouse/Civil Union/Domestic Partner	Last Name	First Name	MI	Date of Birth (mm/dd/yy)	Gender (M/F)	Social Security Number	Dependent's HMO Primary Care Physician ID#	Natural (C) Adopted (A) Foster (F) Step (S) Legal Ward (L) See Instructions
<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

5. TYPE OF ACTIVITY

(complete only if requesting changes to existing coverage)

5a. ADDITION OF DEPENDENT

Marriage - Date of Event (mm/dd/yy) _____
 (Copy of Marriage Certificate required)

Former Name _____

Civil Union/Domestic Partner - Date of Event (mm/dd/yy) _____
 (Copy of Certificate of Civil Union or Domestic Partnership required)

Birth of Child Adoption/Guardianship - proof required
 Date of Event (mm/dd/yy) _____

5b. DELETION OF SPOUSE OR PARTNER

Divorce Dissolution of Civil Union Death
 Termination of Domestic Partnership
 Date of Event (mm/dd/yy) _____

5c. DELETION OF CHILD

Deletion of Child - Date of Event (mm/dd/yy) _____
 Child's Name _____
 Child's SSN _____
 Give Reason _____

5d. OTHER CHANGES

Change in last name only (Attach copy of supporting documentation)
 (List former name) _____

Change in Soc. Sec. # (Attach copy of Social Security card)
 (List former Soc. Sec. #) _____

Change in Birth Date (Attach copy of birth certificate)
 (List name and correct date) _____

Other - give reason (i.e., address change, dependent returns from military service) _____

6. EMPLOYEE CERTIFICATION - I certify that all the information supplied on this form is true to the best of my knowledge and that it is verifiable. I understand that if I waive my right to coverage at this time, enrollment is not permissible until the next scheduled open enrollment or if other coverage is lost and proof of loss is provided (HIPAA). I also understand that there is no guarantee of continuous participation by medical providers, either doctors or facilities in the NJ DIRECT and HMO plans. If either my physician or medical center terminates participation in my selected plan, I must select another doctor or medical center participating in that plan 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.

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

Employee Signature _____

Date Completed _____