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 of New Jersey Affidavit Change of Name (this form will need to be Notarized)
- State of New Jersey Health Benefits Applications
  If you are added dependents to your benefits you will need the required documentation

Please submit the completed forms with a copy of your NEW SOCIAL SECURITY CARD to Human Resources.
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 __________

2. MEDICAL COVERAGE

2a. EMPLOYEE SELECTION (Choose only one plan)

HORIZON
☐ NJ DIRECT15 ☐ Aetna Freedom15
☐ NJ DIRECT1525 ☐ Aetna Freedom1525
☐ NJ DIRECT2035 ☐ Aetna Freedom2035

AETNA
☐ Horizon HMO ☐ Aetna HMO
☐ Horizon HMO1525 ☐ Aetna HMO1525
☐ Horizon HMO2030 ☐ Aetna HMO2030
☐ Horizon HMO3035 ☐ Aetna HMO3035

For HMO Plans, enter Primary Care Physician's ID # ____________________________

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

To sign up for a High Deductible Health Plan (HDHP), you must complete a High Deductible Health Plan Application. For more information, see your benefits administrator, or go to www.state.nj.us/treasury/pensions

5d. OTHER CHANGES

☐ Death
☐ Dissolution of Civil Union
☐ Change in last name only (Attach copy of supporting documentation) (List former name) ____________________________
☐ Death
☐ Change in Social 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) ____________________________

DIVISION USE ONLY

EMPLOYER CERTIFICATION

See instructions on reverse

Effective Dates: ______/______/______ Event Reason: ____________________________

Division of Pension and Benefits, P.O. Box 299, Trenton, NJ 08625-0299

HA-0891-0913

DIVISION USE ONLY

EMPLOYER CERTIFICATION

See instructions on reverse

Effective Dates: ______/______/______ Event Reason: ____________________________

Division of Pension and Benefits, P.O. Box 299, Trenton, NJ 08625-0299

HA-0891-0913

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

☐ 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 # ____________________________

☐ Children

☐ Step (S)
☐ Foster (F)
☐ Natural (C)
☐ Adopted (A)
☐ Legal Ward (L)

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

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

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

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

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

☐ Spouse/Civil Union/ Domestic Partner Last Name ____________________________

First Name ____________________________ MI __________ Date of Birth (mm/dd/yy) ______/______/______

Gender(M/F) ____________________________ Social Security Number ____________________________

☐ Children

☐ Step (S)
☐ Foster (F)
☐ Natural (C)
☐ Adopted (A)
☐ Legal Ward (L)

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

☐ Natural (C) Adapted (A) Foster (F) Step (S) Legal Ward (L) See instructions

☐ Add other dependent

☐ Transfer (Area Code) Home Telephone Number ____________________________

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 (HRPA). I also understand that there is no guarantee of continuous participation by medical providers, either doctors or facilities in the 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 ______/______/______