HO-0805-0619

State Health Benefits Program (SHBP) • School Employees' Health Benefits Program (SEHBP)

CHAPTER 375 APPLICATION
Coverage of a Child Up to Age 31

1. COVERED CHILD'S INFORMATION — Child's name *(last, first)*

Gender	Birth Date	Social Security Number
	/ /	

Telephone Number	Personal Email Address
( )	

Home Address No. and Street Name

City | State | Zip

Marital Status *(check one)*

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

Relationship to Employee/Retiree *(check one)*

☐ Natural Child ☐ Adopted ☐ Stepchild ☐ Other *(explain)* _____

2. COVERED PARENT'S INFORMATION — Parent's name *(last, first)*

Gender	Birth Date	Social Security Number
	/ /	

Telephone Number	Personal Email Address
( )	

Home Address No. and Street Name

City | State | Zip

3. BILLING ADDRESS *(If different from child's address)*

City | State | Zip

DIVISION USE ONLY

Effective Dates

H _____ _____ _____

P _____ _____ _____

Location #

Note: Eligibility under P.L. 2005, c. 375, is limited to a subscriber's child under the age of 31; who is unmarried; has no dependent(s) of his/her own; is a resident of New Jersey or a full-time student at an accredited public or private institution of higher education; and is not provided coverage as a subscriber, insured, enrollee, or covered person under a group or individual health benefits plan, church plan, or entitled to benefits under Medicare. Coverage is limited to the SHBP or SEHBP medical and prescription drug plans that are identical to the plans in which the parent is enrolled. The covered parent is responsible for the entire cost of coverage. Proof of child's age and transcripts for students attending school outside of the State of New Jersey are required.

4. CHAPTER 375 COVERAGE ELECTION

Under Chapter 375, an over age child does not have any choice in the selection of benefits but is enrolled for coverage in exactly the same plan or plans (medical and/or prescription drug) that the covered parent has selected. There is no provision for eligibility for dental or vision benefits.

☐ **I wish to be enrolled in the same plan as my parent under the provisions of P.L.2005, c.375.**

Enter the Physician ID# if enrolling in a HMO

☐ **I wish to terminate all coverage under P.L. 2005, c. 375. Date** _____/_____/_____

5. 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 hereby make application to extend group insurance coverage under the terms of P.L. 2005, c. 375. I authorize the NJDPB to bill me for the monthly premium payments and further agree to make payments in a timely fashion. I understand this coverage will terminate without notice if payment is not made on time. 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 child as the assignee may require. I agree to notify the Health Benefits Bureau if my covered child becomes covered under another group health plan or becomes entitled to Medicare after electing coverage under Chapter 375, or otherwise becomes ineligible for any reason (see Note above). **Misrepresentation:** Any person that knowingly provides false or misleading information is subject to criminal and civil penalties pursuant to N.J.S.A.17:33A-6c.

***See Instructions page for detailed information and Mailing Address**

6. _____ _____/_____/_____

SHBP/SEHBP Covered Parent's Signature **Date Completed**

_____ _____/_____/_____

SHBP/SEHBP Covered Child's Signature **Date Completed**

DO NOT SEND PAYMENT WITH APPLICATION — YOU WILL BE BILLED