



State of New Jersey • Department of the Treasury

DIVISION OF PENSIONS & BENEFITS — HEALTH BENEFITS BUREAU

P.O. Box 299, Trenton, NJ 08625-0299

ACTIVE SHBP/SEHP MANUAL OVERRIDE FORM

Note: Override request must be reviewed and approved by NJDPB staff

PART 1 — MEMBER INFORMATION

Member's Name _____
Last *First* *MI*

Member's Social Security Number _____ Gender _____

Date of Birth ____/____/____ Marital Status _____

Street Address _____
Street *City* *State* *Zip*

Phone Number _____ Email _____

Member Action (Choose one)

New Enrollment (Date Employment Began) _____
Month *Day* *Year*

Transfer Date _____
Month *Day* *Year*

Return From Leave Of Absence _____
Month *Day* *Year*

Other Reason (Effective Date) _____
Month *Day* *Year*

Reason _____

Level of Coverage (Choose one)

Member Only

Member + Spouse/Civil Union/Domestic Partner

Member + Child

Family

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PART 2 — DEPENDENT INFORMATION

List all eligible dependents and attach required proof of dependency documents. Find documentation requirements on the "I Want to Learn About Dependent Verification" page on mynjbenefitshub. Dependents not listed will be removed from coverage.

Dependent 1: Name _____
Last *First* *MI*

Relationship to Member Spouse Civil Union Partner Domestic Partner

Social Security Number _____ Gender _____ Date of Birth ____/____/____

Dependent 2: Name _____
Last *First* *MI*

Social Security Number _____ Gender _____ Date of Birth ____/____/____

Child's Relationship to Member

Natural Child Adopted Child Stepchild Foster Child Legal Ward

Dependent 3: Name _____
Last *First* *MI*

Social Security Number _____ Gender _____ Date of Birth ____/____/____

Child's Relationship to Member

Natural Child Adopted Child Stepchild Foster Child Legal Ward

Dependent 4: Name _____
Last *First* *MI*

Social Security Number _____ Gender _____ Date of Birth ____/____/____

Child's Relationship to Member

Natural Child Adopted Child Stepchild Foster Child Legal Ward

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PART 3 - APPEAL INFORMATION

Employer Name _____

Employer Group Type State Local Government Education

Payroll Number (State Biweekly) _____ Employer ID/Location Number _____ - _____

10/12 Month Employee? _____ Plan Type Medical Plan Election Dental Plan Election

Plan Name and Carrier (Example: Horizon NJ DIRECT10) _____

Reason for Appeal

Certifying Officer's Signature _____

Certifying Officer's Phone Number (_____) _____

Date of Appeal Request ____ / ____ / ____

Return completed form to: **Email: Your Designated NJDPB Health Benefits Group Email Box:**
HBStateColleges@treas.nj.gov
HBStateActive@treas.nj.gov
HBLocalGov@treas.nj.gov
SEHBP@treas.nj.gov

Fax: (609) 341-3407

Mail: New Jersey Division of Pensions & Benefits
Health Benefits Bureau
P.O. Box 299
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