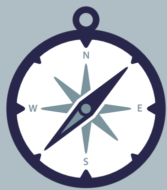
Application for Continued Enrollment for Dependents with Disabilities



NJDPB
Pensions & Benefits
Explore Your Benefits

State Health Benefits Program
School Employees Health Benefits Program

READ THESE INSTRUCTIONS CAREFULLY BEFORE COMPLETING THE ATTACHED APPLICATION

Part 1: Instructions For The Subscriber

1. Read the Eligibility Requirements below.
2. Provide all information requested in Part 1.
3. If necessary, attach additional information on a separate sheet of paper.
4. Read the conditions contained in Part 1, sign and date where indicated.
5. Take this form to the child's attending practitioner for completion of Part 2.
6. Include a photocopy of the first page of your most recently filed tax return, listing the child as a dependent. You may black out all financial information.
7. Include a photocopy of your child's most recently filed tax return, if applicable. Do not black out any financial information.

Part 2: Instructions For The Practitioner

1. Provide all information requested in Part 2.
2. Attach any additional information on a separate sheet of paper.
3. Forward this completed form and any additional information to:

New Jersey Division of Pensions & Benefits
Health Benefits Bureau
P.O. Box 299
Trenton, NJ 08625-0299

Eligibility Requirements

1. The child must be unmarried. If the child marries after approval of continued coverage, the coverage will terminate.
2. The child must be regarded by the SHBP or SEHBP Medical Advisors as incapable of self-sustaining employment due to mental illness, mental retardation, and/or physical disability.
3. The child must be principally dependent upon the subscriber for support and maintenance.
4. The child must have become incapable of self-support prior to the end of the calendar year in which the child attained the age of 26.
5. The child must have been covered as a dependent under a SHBP or SEHBP contract prior to attaining the age of 26.
6. This *Application For Continued Enrollment for Dependents With Disabilities* must be submitted to the Health Benefits Bureau no later than January 31st of the year following the calendar year in which the child attained the age of 26.

HB-0810-0121

State of New Jersey • Department of the Treasury

DIVISION OF PENSIONS & BENEFITS — HEALTH BENEFITS BUREAU

P.O. Box 295, Trenton, NJ 08625-0295

APPLICATION FOR CONTINUED ENROLLMENT FOR DEPENDENTS WITH DISABILITIES

Please read instructions carefully before completing the application.

PART 1 — Subscriber & Dependent Information

1a. Subscriber's Name ____
Last *First* *Middle Initial*

1b. Subscriber's Email Address ______________________________________

1c. Phone Number ______________________ 1d. Social Security Number ______________

1e. Mailing Address ____
Street *City* *State* *Zip Code*

2a. Dependent's Name ____
Last *First* *Middle Initial*

2b. Relationship to Subscriber ________________ 2c.Dependent's Marital Status ____________

2d. Date of Birth ____________________ 2e. Date of Onset of Disability ____________

3. Name of Current Health Plan ______________________________________

4a. Can the dependent perform the activities of daily living listed below? Check all that apply.

☐ Bathing ☐ Dressing ☐ Eating ☐ Toileting ☐ Transferring from/to chair/bed

4b. Is dependent able to ☐ Move about independently ☐ Travel independently ☐ Manage finances

4c. Is dependent homebound? ☐ Yes ☐ No

5a. Does the dependent currently work for wages? ☐ Yes ☐ No (If No, see 5c).

Name of Employer ____________________ Weekly Hours __________ Annual Salary __________

5b. Has the dependent ever worked for wages? ☐ Yes When? ______________ ☐ No (If No, see 5c).

Name of Employer ____________________ Weekly Hours __________ Annual Salary __________

5c. If the dependent is no longer working or has never worked, please explain why ____________________

____

6. Is the dependent eligible for health coverage through his/her employer? ☐ Yes ☐ No

7. Does the dependent currently attend or have they ever attended College or a Vocational Training program designed to increase functionality? ☐ Yes ☐ No If Yes, when? ____________ Name of School or Program ______________

8. What are the specific ways in which you support or maintain the dependent? ____________________

____

9. Is the dependent confined to an Institution? ☐ Yes ☐ No

If Yes, give name and location ____

PART 1 — Subscriber & Dependent Information *(continued)*

10. Please list the sources of financial support for the dependent.

    ____ Percentage of support ___________%

    ____ Percentage of support ___________%

11. If the dependent does not live at home give current address ____

12. Has the dependent applied for SSI/Medicare/Medicaid? ☐ Yes ☐ No

    If Yes, please list type(s) and attach award letter dated within the last two years ________________________________

    If No, please explain why ____

13. I understand and agree that continuation of enrollment for the child named above, if approved, may remain in effect only as long as the mental impairment and/or physical disability and dependency exist, and so long as SHBP or SEHBP coverage, in my name or in the name of my spouse, if any, remains in force. I further understand and agree that the SHBP or SEHBP shall have the right to require periodic recertification as to eligibility for continued extension of dependency coverage.

    I represent that to the best of my knowledge and belief the information given above is correct, and that the child named above meets the eligibility requirements as to unmarried status and enrollment under my coverage, and is dependent upon me for more than 50 percent of his/her support and maintenance.

    Any person who knowingly and with intent to defraud, files a statement containing materially false information, or conceals information for the purpose of misleading, commits a fraudulent insurance act which is a crime.

____ _____/_____/______

Member's Signature *mm dd yyyy*

HB-0810-0121

State of New Jersey • Department of the Treasury
DIVISION OF PENSIONS & BENEFITS — HEALTH BENEFITS BUREAU
P.O. Box 295, Trenton, NJ 08625-0295

APPLICATION FOR CONTINUED ENROLLMENT FOR DEPENDENTS WITH DISABILITIES

PART 2 — Disability Information To Be Completed by the Dependent's Attending Practitioner

Note: If this document is illegible or incomplete, it will be returned. If more information needs to be provided, please attach additional pages. Please forward completed form and any additional information to the subscriber.

Subscriber's Name ____________________

Dependent's Name ____________________

1. Diagnosis(es) — Must provide narrative text in addition to ICD9-11 or DSM-111 codes:

   a. ____________ ____________________

   b. ____________ ____________________

   c. ____________ ____________________

2. If mentally impaired, define mental impairment in terms of mental age _________, IQ ________ or must provide a detailed explanation of functional capacity, limitations, and ability to function in a work, educational, and social setting. **Note:** Must also provide a summary of most recent testing done to define functional level.

   ____

   ____

3. If physically impaired, define physical impairment in terms of capacity to perform activities normally done by individuals of comparable age and intellectual capacity. **Note:** Must also provide a summary of most recent testing done to define functional level.

   ____

   ____

4. If behaviorally impaired, define the dependent's functional capacity, limitations, and ability to perform work, educational, and social activities normally done by individuals of comparable age.

   a. Is dependent able to understand or follow instructions? ☐ Yes ☐ No

   b. Does dependent's emotional state prevent him/her from concentrating on a task? ☐ Yes ☐ No

   c. Can dependent tolerate a work environment? ☐ Yes ☐ No

   d. Why could a dependent not work at home? ____________________

   Please provide a detailed explanation of behavioral health disabilities here. **Note:** Must also provide a summary of most recent testing done to define functional level ____________________

   ____

5. Assessment of the current clinical status and plans for future treatment ____________________

   ____

6a. Is the condition static or progressive? ☐ Static ☐ Progressive Must explain ____________________

____

6b. Is the condition permanent or temporary? ☐ Static ☐ Progressive Must explain ____________________

____

PART 2 — Disability Information To Be Completed by the Dependent's Attending Practitioner *(continued)*

7. Is the condition currently controlled with treatment or has been controlled with treatment? ☐ Yes ☐ No

   Must explain how treatment is or is not controlling dependent's condition ______________________________

   ____

8. Is the patient complying with treatment? ☐ Yes ☐ No

9a. In your professional opinion, is the dependent able to work or attend school/vocational training program/other job preparation program that would make the dependent self-supporting? Must explain ______________________________

   ____

9b. If the dependent cannot work or attend a school/vocational training program, what exactly prevents him/her from working or attending school/vocational training programs? Must explain ______________________________

   ____

10. Describe the special supervisory, physical assistance, or custodial care required by dependent. Must explain ____________

   ____

11. If the dependent is attending college, working, or in a training program, what makes this individual more reliant on a parent for support and maintenance than his/her non-disabled peers? Must explain ______________________________

   ____

12. If the dependent's parents were suddenly no longer able to help, would the dependent be able to function independently or would he/she become a ward of a social agency? Must explain ______________________________

   ____

Please print the answers to all of the questions below and then provide your signature and date of completion.

I hereby certify that I am a practicing ____________________ duly licensed in the State of ____________________

Practitioner's Name ____

Practitioner's Address ____

Street *City* *State* *Zip Code*

National Provider Number (NPI) ____________________ Practitioner's Phone Number ____________________

Date of Dependent's Last Examination _____/_____/_____

mm dd yyyy

____ _____/_____/_____

Practitioner's Signature *mm dd yyyy*

PART THREE — To Be Completed by SHBP Medical Advisor

Continuation of enrollment of the dependent named above under his/her parent's coverage IS / IS NOT approved.

This certification applies to all coverage. ☐ Permanent ☐ Temporary Duration of Continuance ____________________

Name of Medical Director (please print) ____

____ _____/_____/_____

Authorized Signature *mm dd yyyy*

Rationale for Determination ____

____

____

Health Benefits Coverage Continuation for Over Age Children With Disabilities

Information for:
State Health Benefits Program (SHBP)
School Employees' Health Benefits Program (SEHBP)

TERMINATION OF COVERAGE FOR OVER AGE DEPENDENTS

The eligibility of a dependent child covered under your benefits through the State Health Benefits Program (SHBP) or School Employees' Health Benefits Program (SEHBP) ends on December 31 of the year in which he or she turns 26 years of age. However, an over age child who is disabled due to a mental or physical disability and dependent upon you for support can remain covered as a dependent if the child's disabled status is approved.

Per N.J.A.C. 17:-9-3.4(c), SHBP or SEHBP coverage for an over age child with disabilities must be continuous. If the member waives coverage for any reason, the child may not be added again at a later date. This includes cases where an employee waives active coverage and resumes coverage as a retiree.

CONTINUATION OF COVERAGE FOR A CHILD WITH A DISABILITY

In the fall of the year your dependent child turns 26, you are notified of the impending termination via a Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) eligibility notice* (see the "COBRA" section). If the child is physically and/or mentally unable to provide for him or herself, you may request an *Application for Continued Enrollment for Dependents with Disabilities.* The application and proof of the child's condition must be received by the New Jersey Division of Pensions & Benefits' (NJDPB) Health Benefits Bureau no later than 31 days after December 31 of the year your child turns 26. It is then sent to Horizon for review and approval. Once continued coverage is approved, it will generally be reinstated retroactively to the date coverage terminated due to turning age 26. To obtain an application, visit our website at: ***www.nj.gov/treasury/pensions*** or write to:

New Jersey Division of Pensions & Benefits
Health Benefits Bureau
P.O. Box 299
Trenton, NJ 08625-0299

The *Application for Continued Enrollment for Dependents with Disabilities* includes a section to be completed by a physician describing the dependent's disability. Horizon's Medical Review Board must assess each case, and may request that the member provide additional medical documentation that the Board finds necessary to make an informed determination; prior approval from a previous insurer is not acceptable.

If Horizon's Medical Review Board determines that the dependent child is eligible for continued coverage, it may continue only while (1) you remain covered through the SHBP or SEHBP; (2) the child continues to be disabled; (3) the child is unmarried; and (4) the child remains dependent on you for support and maintenance. You will be contacted periodically to verify that the child remains eligible for continued coverage by Horizon.

BOARD OF EDUCATION RETIREES

School board employees who are retiring with 25 or more years of service credit, and whose employers do not participate in the SEHBP, can request to cover an over age dependent with a disability when applying for their own SEHBP Retired Group coverage. The process is the same as described in the "Continuation of Coverage for a Child with a Disability" section, except that the SEHBP must also receive a letter from the board of education certifying that the dependent was covered by the board's group health insurance during the member's active employment up until retirement. Because SEHBP Retired Group coverage is intended to be a continuation of previous employee coverage, the dependent will be denied coverage if not previously covered by the board of education's group health insurance.

LOCAL POLICE AND FIRE RETIREES

Local retirees from the Police and Firemen's Retirement System (PFRS), or Law Enforcement Officer members of the Public Employees' Retirement System (PERS), who are eligible for enrollment in the SHBP under P.L. 1997, c. 330 (Chapter 330), can

For active employees, your employer will receive a listing of members whose dependents have turned age 26. The employer then sends the COBRA notification to their employees advising of the termination. Retirees are notified about COBRA eligibility by a letter from the Health Benefits Bureau to the current address on file.

request to cover an over age dependent with a disability when enrolling in SHBP Retired Group coverage. The process is the same as described in the "Continuation of Coverage for a Child with a Disability" section, except that the SHBP must also receive a letter from the former employer certifying that the dependent was covered by the employer's group health insurance during the member's active employment up until retirement. Because SHBP Retired Group coverage is intended to be a continuation of previous employee coverage, the dependent may be denied coverage if not previously covered by the employer's group health insurance.

For more information about Chapter 330, see the *Health Benefits Retired Coverage Under Chapter 330* Fact Sheet. The fact sheet is available on our website.

EMPLOYERS JOINING THE SHBP OR SEHBP

When an employer resolves to join the SHBP or SEHBP, over age dependent children with disabilities may be enrolled for coverage provided they were covered as a dependent under the employer's health plan immediately preceding entrance into the Program. The employer must certify that the dependent was covered under the former plan. The employee must request an *Application for Continued Enrollment for Dependents with Disabilities,* and coverage must be approved by the Medical Review Board based upon a determination of the child's disabled status.

NEW EMPLOYEES

New employees of a participating SHBP or SEHBP employer will not normally be able to obtain coverage for an over age dependent, because providing this coverage would not represent a continuation of previous coverage. There are two exceptions to this rule: first, when the former employer participates in the SHBP or SEHBP and the dependent is already covered in the program as an approved over age dependent; and second, when the new employee is transferring to the participating SHBP employer through the Intergovernmental Transfer Program, which is described below.

INTERGOVERNMENTAL TRANSFER PROGRAM

Dependent children with disabilities age 26 or older may be enrolled in SHBP coverage when their parent transfers public employment to a SHBP-participating employer through the Intergovernmental Transfer Program. This program provides the opportunity for New Jersey State and local government employees with permanent civil service status to transfer between State and local employment jurisdictions. To be eligible, the child must have been covered as a dependent under the parent's health plan immediately preceding enrollment into the SHBP, and an *Application for Continued Enrollment for Dependents with Disabilities* must be requested. Continued coverage is dependent upon a determination of the child's disabled status by the Horizon's Medical Review Board.

INTERIM OR ALTERNATIVE COVERAGE FOR OVER AGE CHILDREN

If Horizon's Medical Review Board denies continued health benefit coverage for your over age child, or if you wish to ensure that your child has some form of health benefit coverage from January 1 until the Medical Review Board's decision, you may enroll your child in either COBRA or coverage under the provisions of P.L. 2005, c. 375 (Chapter 375). Rates for COBRA and Chapter 375 coverage can change annually; be sure to compare the rates prior to enrolling in either program. To see a cost comparison, visit our website. If the dependent's coverage is reinstated retroactively, COBRA or Chapter 375 premiums will be reimbursed.

COBRA

In the year in which your dependent child turns age 26, you will receive a COBRA notification letter prior to the termination of the dependent's coverage, which is required by federal law. The *COBRA Notice* outlines the right to purchase continued health coverage, gives the date coverage will end, and the period of time over which coverage may be extended (usually 36 months).

Chapter 375

Chapter 375 gives certain dependents over age 26 and under age 31 the opportunity to purchase continued coverage in exactly the same plan or plans (medical and/or prescription drug) that the covered parent has selected. Chapter 375 does not cover vision and dental benefits; if your child wishes to continue those coverages, he or she must apply for them under COBRA when first eligible.

Note: The *COBRA Application* and/or *Chapter 375 Application* must be filed within 60 days of the dependent's loss of coverage.

If you need information concerning COBRA coverage, see the *COBRA — The Continuation of Health Benefits* Fact Sheet.

For more information about Chapter 375, see your employer or the *Health Benefits Coverage of Children Until Age 31 Under Chapter 375* Fact Sheet, available on our website.

This fact sheet has been produced and distributed by:

New Jersey Division of Pensions & Benefits
P.O. Box 295, Trenton, NJ 08625-0295

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For the hearing impaired: TRS 711 (609) 292-6683
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