## CANCEL/DECLINE/WAIVE RETIRED COVERAGE FORM

State Health Benefits Program – School Employees' Health Benefits Program

New Jersey Division of Pensions and Benefits Program PO Box 299 o Trenton, NJ 08625-0299

Check applicable box: I Medical Only I Dental Only I Both **  you are newly eligible to enroll and wish to waive only one type of coverage, you must also see coverage of your choice.  f you are currently enrolled in the SHBP/SEHBP and wish to waive only one type of type of coverage.  I certify that all the information supplied on this form is true to the	WAIVE COVERAGE – FOR THOSE THAT HAVE OTHER COVERAGE AND MAY WISH TO ENROLL LATER  NOTE: Waiver allowed only for other employer or spouse's employer coverage. Re-enrollment is not permitted if other coverage is private insurance.  Retirees are permitted to enroll in medical but waive dental coverage, or to enroll in dental but waive medical coverage, or to waive both.  I am newly eligible to enroll, but am enrolled in another group plan and wish to waive coverage. In order to enroll with the SHBP/SEHBP at a later date, I understand that I must submit a Retired Change of Status Application, along with proof of coverage loss, within 60 days of losing the other coverage.  Check applicable box: I Medical Only I Dental Only I Both *	CANCEL / DECLINE ALL COVERAGE - FOR THOSE THAT DO NOT WANT COVERAGE, PERMANENTLY  I am newly eligible to enroll, but I wish to decline all coverage. I understand that I will not be permitted to enroll with the SHBP/SEHBP at a later date.  I am currently enrolled and wish to cancel all coverage. I understand that I will not be permitted to enroll with the SHBP/SEHBP at a later date.  I wish to decline/cancel my SHBP/SEHBP DENTAL coverage only. I understand that I will not be permitted to enroll in the SHBP/SEHBP dentiplans at a later date. My enrollment in medical coverage will not be affected.	Social Security Number  Last Name  Last Name  PO Box or Street Address (Include Apartment #)  Area Code  Home Telephone Number  Status (check one)  Former Employer:  Former Employer:
Application, along with proof of coverage loss, within 60 days of losing the other coverage.  I Dental Only I Both **  In order to re-enroll later, I understand that Application, along with proof of coverage loss, within 60 days of losing the other coverage.  I Dental Only I Both **  In order to re-enroll later, I understand that I understand the other coverage.  I Dental Only I Both **  I Dental Only I Both **  I	AT HAVE OTHER COVERAGE AND MAY WISH TO ENROLL LATER bloyer coverage. Re-enrollment is not permitted if other coverage is private insurance. erage, or to enroll in dental but waive medical coverage, or to waive both. oup plan and wish to waive coverage. In order to enroll with the SHBP/SEHBP at a later is Application, along with proof of coverage loss, within 60 days of losing the other coverage.	- FOR THOSE THAT DO NOT WANT COVERAGE, PERMANENTLY age. I understand that I will not be permitted to enroll with the SHBP/SEHBP at a later date. Inderstand that I will not be permitted to enroll with the SHBP/SEHBP at a later date. Verage only. I understand that I will not be permitted to enroll in the SHBP/SEHBP dental will not be affected.	8!

Date