

**STATE OF NEW JERSEY**  
**DIVISION OF PENSIONS AND BENEFITS**  
**ALTERNATE BENEFIT PROGRAM**  
**ABP LONG TERM DISABILITY INSURANCE**  
**APPLICATION INSTRUCTIONS**

**THIS PACKET CONTAINS:**

***Prudential Group Disability Insurance Application***

- Employee Statement
- Employer Statement
- Attending Physician Statement
- Employee Tax Notice
- Insurance Authorization
- Electronic Funds Transfer Authorization

***ABP Long Term Disability Carrier Election Allocation***

***SHBP/SEHBP Retired Coverage Enrollment Application***

1. An Alternate Benefit Program (ABP) member wishing to apply for a long term disability begins the process by completing the *Disability Insurance Application, Carrier Election and Allocation* form, and *SHBP/SEHBP Retired Coverage Enrollment Application* — accurately providing all requested information and submitting the complete packet to his or her Employer.
2. The employer then provides the employee's salary information for the final 12 months prior to the month in which the disabling event occurred, and sends the completed applications and forms to:

**The Division of Pensions and Benefits**  
**Alternate Benefit Program**  
**PO Box 295**  
**Trenton, NJ 08625-0295**

3. Upon receipt, the Division of Pensions and Benefits informs the New Jersey SHBP/SEHBP that an ABP long term disability is pending.
4. The Division of Pensions and Benefits then forwards the employee's application to Prudential for initial processing.
5. ABP long term disability processing times vary. If any required information is missing from the application, Prudential will contact the employee or the employer to obtain the necessary information.
6. When all required information has been obtained, Prudential makes a determination as to whether or not the disability is approved and notifies the employee directly. The employer and the Division of Pensions and Benefits are also notified of the determination.

For additional information or if you have questions, contact Prudential at 1-800-842-1718 or write to the Alternate Benefit Program at the address listed above.



The Prudential Insurance Company of America  
Disability Management Services  
P.O. Box 13480, Philadelphia, PA 19176  
Tel: 800-842-1718 Fax: 877-889-4885  
<http://www.prudential.com/mybenefits>

Disability Claim Instructions

Submitting a Claim

The first three steps are required.

1. Notify your employer of your absence. Inform your employer that you'll be filing a disability claim. Ask your employer to complete the **Employer's Statement** and submit it to Prudential.
2. Complete all sections of the **Employee's Statement** and submit it to Prudential.  
(If you prefer, you may complete and submit the Employee's Statement online. Go to [www.prudential.com/mybenefits](http://www.prudential.com/mybenefits). Your online submission will save time at the beginning of your claim-filing process.)
3. Ask your doctor to complete the **Attending Physician's Statement** and submit it to Prudential. Check with your Benefits Office to see if there are any additional requirements.

Steps 4 through 6 are voluntary.

4. Complete all sections of the **Group Disability Insurance Authorization**.  
(If additional medical information is needed to review your claim, submitting this form now may reduce the time needed to reach a decision.)
5. If you want voluntary Federal Income Tax withheld from your disability benefit payments — read and complete the **Group Disability Insurance Tax Notice**.
6. If you want electronic fund deposits of your disability benefit payments — read and complete the **Group Disability Insurance Electronic Funds Authorization**.

Prudential considers a claim to be filed when the **Employer's Statement, Employee's Statement, and Attending Physician's Statement** have been submitted, and specific elimination period requirements have been met — as specified below.

- **If you have Long-Term Disability (LTD) coverage** with Prudential, your claim for LTD benefits will be considered filed, when you meet **both** of these two criteria. **1** We receive the Employee's Statement, the Employer's Statement, and the Attending Physician's Statement. **2** The date is 45 days before the end of your LTD elimination period.



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**Employee Statement**
**1 Employer Information**

Employer Name  Control Number

Location/Division  Branch Number

**2 Employee Information**

First Name  MI  Last Name

Address 1  Social Security Number

Address 2  Telephone Number

City  State  Zip

Birth Date (MM DD YYYY)  Gender  Male  Female Marital Status  Unmarried  Married  Divorced  Widowed

Email Address  Work Telephone Number

Date Last Worked (MM DD YYYY)  Date First Absent (MM DD YYYY)  Date First Treated for this Condition (MM DD YYYY)

Date Expected to Return to Work (MM DD YYYY)  Spouse's Date of Birth (MM DD YYYY)  Is Spouse Employed?  Yes  No

Education: Highest Grade Completed  Number of Children Under 18  Age of Youngest Child

**3 Job Information**

Occupation  DOT Job Code \_\_\_\_\_

What Job Category best describes the claimant's essential job duties? (Please check the appropriate box)

**Sedentary**  **Light**  **Medium**  **Heavy**  **Very Heavy**

Negligible Weight Mostly Sitting Up to 10 lbs. frequently Up to 20 lbs. occasionally and/or Frequent Walk/Stand and/or Constant Push/Pull Up to 25 lbs. frequently Up to 50 lbs. occasionally 25 to 50 lbs. frequently 50 to 100 lbs. occasionally More than 50 lbs. frequently 100 lbs. occasionally

**Other** (Please describe)



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**4 Primary Care Physician**

Physician First Name	MI	Physician Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>
Primary Telephone Number	Fax Number	
<input type="text"/>	<input type="text"/>	<input type="text"/>
Office Address	Suite	
<input type="text"/>	<input type="text"/>	
City	State	ZIP Code
<input type="text"/>	<input type="text"/>	<input type="text"/>
Specialty		
<input type="text"/>		

**5 Medical Information**
**All Other Physicians You Have Consulted for this Condition** (Attach an additional sheet if necessary)

Physician First Name	Physician Last Name
<input type="text"/>	<input type="text"/>
Specialty	Telephone Number
<input type="text"/>	<input type="text"/>
Physician First Name	Physician Last Name
<input type="text"/>	<input type="text"/>
Specialty	Telephone Number
<input type="text"/>	<input type="text"/>
Physician First Name	Physician Last Name
<input type="text"/>	<input type="text"/>
Specialty	Telephone Number
<input type="text"/>	<input type="text"/>

What medical condition is preventing you from working?

How does this condition interfere with your ability to perform your job?

 Have you ever been hospitalized for this condition?  Yes  No  Inpatient  Outpatient

If Hospitalized Give Dates (MM DD YYYY)

From	To
<input type="text"/>	<input type="text"/>

If You are Pregnant:

Estimated Delivery Date: (MM DD YYYY)	Actual Delivery Date (MM DD YYYY)
<input type="text"/>	<input type="text"/>

Name of Your Health Insurance company

<input type="text"/>	Telephone Number
<input type="text"/>	<input type="text"/>



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## 6 Other Income and Workers' Compensation Information

What other income are you entitled to receive as a result of your disability? (Examples: Social Security Disability or Retirement Benefits, Workers' Compensation, State Disability, Pension Disability or Retirement, No-Fault Auto Insurance, Salary Continuance, Group Life or Disability Plan, Health or Welfare Plan, Individual Disability Benefits.)

Please send copies of any letters or notices approving or denying benefits.

Source	Applied for		Amount	Frequency		Date Benefit Begins			Date Benefit Ends		
	Yes	No		Weekly	Monthly	MM	DD	YYYY	MM	DD	YYYY
Salary Continuance	<input type="checkbox"/>	<input type="checkbox"/>	____.____	<input type="checkbox"/>	<input type="checkbox"/>	__	__	____	__	__	____
State Disability Benefits	<input type="checkbox"/>	<input type="checkbox"/>	____.____	<input type="checkbox"/>	<input type="checkbox"/>	__	__	____	__	__	____
Social Security	<input type="checkbox"/>	<input type="checkbox"/>	____.____	<input type="checkbox"/>	<input type="checkbox"/>	__	__	____	__	__	____
Workers' Compensation	<input type="checkbox"/>	<input type="checkbox"/>	____.____	<input type="checkbox"/>	<input type="checkbox"/>	__	__	____	__	__	____
Medical Deduction	<input type="checkbox"/>	<input type="checkbox"/>	____.____	<input type="checkbox"/>	<input type="checkbox"/>	__	__	____	__	__	____
Dental Deduction	<input type="checkbox"/>	<input type="checkbox"/>	____.____	<input type="checkbox"/>	<input type="checkbox"/>	__	__	____	__	__	____
Vision Deduction	<input type="checkbox"/>	<input type="checkbox"/>	____.____	<input type="checkbox"/>	<input type="checkbox"/>	__	__	____	__	__	____
Life Deduction	<input type="checkbox"/>	<input type="checkbox"/>	____.____	<input type="checkbox"/>	<input type="checkbox"/>	__	__	____	__	__	____
Other	<input type="checkbox"/>	<input type="checkbox"/>	____.____	<input type="checkbox"/>	<input type="checkbox"/>	__	__	____	__	__	____

Is this condition work related?  Yes  No If Yes, do you intend to file a Workers' Compensation claim?  Yes  No

## 7 Correspondence Preference

The Prudential website is a quick, secure way to review the status of your claim and view/print all claim related correspondence.

You have the option to view your correspondence electronically. If you select 'Yes' below, you will receive an e-mail from Prudential instructing you to log onto our website and to accept the web disclosure authorization. Once you enroll in E-Delivery, claim correspondence will only be available on our website, and paper correspondence will no longer be mailed. You will be notified via e-mail when new correspondence is available. You can change your preference at any time on our website.

- Yes, I prefer to receive my correspondence electronically. I understand that all future correspondence related to this claim will be posted to the Prudential website and paper correspondence will no longer be mailed to me.
- No, I prefer my correspondence to be mailed to me.

## 8 Fraud Notice

**FLORIDA RESIDENTS**—Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**NEW YORK RESIDENTS**—Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I have read and understand the terms and requirements of the fraud warnings included as part of this form. I certify that the above statements are true.

Claimant  
Signature

**X**

Date (MM DD YYYY)

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**For residents of all states and jurisdictions except Alabama, Arizona, California, the District of Columbia, Florida, Kentucky, Maryland, New Hampshire, New Jersey, New York, Pennsylvania, Puerto Rico, Rhode Island, Utah, Vermont, Virginia and Washington; WARNING**—Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

**ALABAMA RESIDENTS**—Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

**ARIZONA RESIDENTS**—For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**CALIFORNIA RESIDENTS**—For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**DISTRICT OF COLUMBIA and RHODE ISLAND RESIDENTS**—Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**KENTUCKY RESIDENTS**—Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**MARYLAND RESIDENTS**—Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**NEW HAMPSHIRE RESIDENTS**—Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

**NEW JERSEY RESIDENTS**—Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**PENNSYLVANIA and UTAH RESIDENTS**—Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.



**PUERTO RICO RESIDENTS**—Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

**VERMONT RESIDENTS**—Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

**VIRGINIA RESIDENTS**—Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing a statement of claim for payment of a loss or benefit may have violated state law, is guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

**WASHINGTON RESIDENTS**—Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company commits a crime. Penalties include imprisonment, fines, and denial of insurance benefits.





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Employer Statement

1 Employer Information

Employer's Name, Control Number (required), Street, Suite, City, State, ZIP Code, LTD Branch (required), Employer's Telephone Number, Extension, Email Address

2 Employee Information

First Name, MI, Last Name, Address 1, Social Security Number, Address 2, Telephone Number, City, State, ZIP Code, Gender, Employment Status, Coverage Effective Date, Date Hired, Coverage Termination Date, Last Date Employer Paid Compensation, Date First Absent, Date Last Worked, Date Work Was Resumed, Normal Earnings Prior to this Absence, If employee does not work Monday through Friday, check days worked, Year-to-Date Total Taxable Wages

How was the LTD premium paid for the plan year in which the disability occurred? % paid by employer
Was the premium amount paid by the employer included in the employee's W-2? Yes No
Has either percentage changed within the last 3 years? Yes No





SSN input boxes

3 Other Income, Deductions, and Workers' Compensation Information

Please indicate any applicable deductions such as Local Tax, State Income Tax, Medical, Dental, Life and/or 401(K), that should be withheld from the employee's benefits, if approved. Please also indicate if the employee is receiving, or is eligible to receive, benefits from any other sources because of this absence, such as Salary Continuance, Workers' Compensation, Social Security Disability or Retirement Benefits, Statutory Benefits, No-Fault Auto Insurance, Retirement, or Pension Plan. Please send copies of any letters or notices approving or denying benefits.

Table with columns: Source, Applied for (Yes/No), Amount, Frequency (Weekly/Monthly), Date Benefit Begins, Date Benefit Ends. Rows include Salary Continuance, State Disability Benefits, Social Security, Workers' Compensation, Medical Deduction, Dental Deduction, Vision Deduction, Life Deduction, and Other.

Has the employee indicated that the absence is work related? [ ] Yes [ ] No Has a Workers' Compensation claim been filed? [ ] Yes [ ] No

4 Job Information

Occupation [ ] DOT Job Code \_\_\_\_\_

What job category best describes the employee's essential job duties? (Please check the appropriate box.)

- [ ] Sedentary: Negligible weight, Mostly sitting
[ ] Light: Up to 10 lbs. frequently, Up to 20 lbs. occasionally, and/or Frequent Walk/Stand, and/or Constant Push/Pull
[ ] Medium: Up to 25 lbs. frequently, Up to 50 lbs. occasionally
[ ] Heavy: 25 to 50 lbs. frequently, 50 to 100 lbs. occasionally
[ ] Very Heavy: More than 50 lbs. frequently, 100 lbs. occasionally

[ ] Other (Please describe) [ ]

As the employer, would you be able to accommodate modified duty to facilitate early return to work? [ ] Yes [ ] No

If Yes, please explain (reduced hours, job modification, etc.):

[ ]

5 Life Insurance

Is employee covered under a Prudential Group Life Insurance Policy? [ ] Yes [ ] No

If Yes, what is the face amount? \$ [ ] , [ ] , [ ] . [ ]





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I have read and understand the terms and requirements of the fraud warnings included as part of this form.  
I certify that the above statements are true.

Date (MM DD YYYY)

Employer  
Signature

X

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**For residents of all states except Alabama, Arizona, California, the District of Columbia, Florida, Kentucky, Maryland, New Hampshire, New Jersey, New York, Pennsylvania, Puerto Rico, Rhode Island, Utah, Vermont, Virginia, and Washington; WARNING:** Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive, or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages, and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

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Attending Physician Statement

1 Employee Information

Employer's Name, Control Number (required), Employee First Name, MI, Last Name, Claim Number, Social Security Number, Date of Birth (MM DD YYYY), Gender (Female, Male)

I hereby authorize the release of information requested on this form by the below named physician for the purpose of claim processing.

Employee Signature (with X), Date (MM DD YYYY)

The Employee is responsible for the completion of this form without expense to Prudential.

2 To Be Completed by Attending Physician

Clinical Diagnosis, ICD-9 Code is Required, Pregnancy EDC (MM DD YYYY), Actual Delivery Date (MM DD YYYY), Secondary, Date when significant loss of function occurred: (MM DD YYYY)

Do you feel the claimant is competent to endorse checks and direct the use of proceeds? Yes No

Return to Work Target Date (MM DD YYYY), Full-Time, Part-Time, With Limitations (functions lost)

Please describe Return to Work Plan and provide any corresponding Limitations:

Please describe any Medical Obstacles to Return to Work:

Nature of Medical Impairment (i.e., loss of function):

Are there any Non-Medical Factors which have a significant impact on Functional Abilities (i.e., interpersonal, financial, family)?

Check all that apply to this disability:

Work Related, Accident, Sickness, Maternity, Motor Vehicle Accident, If MVA, in what State did it occur? (Yes/No checkboxes)

Other Treating Physicians or Consultants:

First Name, Last Name, Specialty, Telephone Number





Employee First Name  MI  Last Name   
 Claim Number  Date of Birth (MM DD YYYY)  Employee's Social Security Number

## 2 Attending Physician Information (Cont'd.)

### Other Treating Physicians or Consultants

First Name  Last Name   
 Specialty  Telephone Number   
 Date of Surgical Procedure (MM DD YYYY)

Relevant tests and surgical procedure (s) performed (please be specific):

Current Medications, Treatment, and Prognosis:

First Visit (MM DD YYYY)  Last Visit (MM DD YYYY)  Next Visit (MM DD YYYY)

Was Claimant hospital confined?  Yes  No

If yes, please provide name and address of hospital:   
  
 From (MM DD YYYY)   
 To (MM DD YYYY)

## 3 Physician Information

First Name  MI  Last Name   
 Primary Telephone Number  Fax Number   
 Office Address  Suite   
 City  State  ZIP Code   
 Specialty

## 4 Fraud Notice

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I have read and understand the terms and requirements of the fraud warning and I certify the above statements are true.

Physician Signature   Date (MM DD YYYY)





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Group Disability Insurance Authorization

1 Claimant's Information

Form fields for First Name, MI, Last Name, Social Security Number, Employee Phone Number, and Control Number.

2 Authorization for Release of Information to Prudential Insurance Company

This authorization is intended to comply with the HIPAA Privacy Rule.

I authorize and instruct any health plan, physician, health care professional, medical professional, hospital, clinic, laboratory, pharmacy, clearinghouse, data warehouse, or other organization that aggregates and maintains pharmacy data, MIB, Inc. (formerly known as the Medical Information Bureau), medical facility, or other health care provider or insurance company or producer that has provided treatment, payment, or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other information concerning me or my mental or physical health to the Prudential Insurance Company of America (Prudential) and its agents, employees, and representatives.

I authorize any insurance company, employer, the Social Security Administration, or other person or institutions to provide any information, data, or records relating to my Social Security, Workers' Compensation, credit, financial, earnings, activities, or employment history to Prudential.

For purposes of this Authorization, I acknowledge that any agreements I have made with My Providers that restricts the disclosure of my protected health information as described above do not apply to this Authorization and I instruct My Providers to release and disclose my entire medical record without restriction, including any restrictions on healthcare items or services for which a healthcare provider has been paid out of pocket in full.

This information is to be disclosed under this Authorization so that Prudential may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) obtain reinsurance; 3) administer coverage; and 4) conduct other legally permissible activities that relate to any coverage or benefits I have or have applied for with Prudential.

This Authorization shall remain in force for 24 months following the date of my signature below, while the coverage is in force, except to the extent that state law imposes a shorter duration. A copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to Prudential at: P.O. Box 13480, Philadelphia, PA 19176. I understand that a revocation is not effective to the extent that any of My Providers or Prudential has relied on this Authorization or to the extent that Prudential has a legal right to contest a claim under any insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and will no longer be protected by the HIPAA Privacy Rule governing privacy and confidentiality of health information.

I understand that if I refuse to sign this Authorization to release the entire medical record, Prudential may not be able to process my claim for benefits and may not be able to make any benefit payments. I understand that I have the right to receive a copy of this Authorization.

Authorization for Release of Information to Prudential Insurance Company

X \_\_\_\_\_ Date (mm dd yyyy)
Employee Signature (indicate how related if signed by other than claimant)

NOTICE TO MONTANA RESIDENTS: You or your authorized representative are entitled to receive a copy of this Authorization, and upon request, a record of any subsequent disclosures of personal or privileged information.





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Disability Management Services
P.O. Box 13480, Philadelphia, PA 19176
Tel: 800-842-1718 Fax: 877-889-4885
www.prudential.com/mybenefits

Group Disability Insurance
Electronic Funds Transfer Authorization

1 Enrollment

To enroll in Prudential's Electronic Funds Transfer (EFT) payment service, please provide the following information. If you elect to have Prudential deposit the funds in your savings or checking account, you must first check with your bank to obtain the correct bank transit routing number and account number for electronic deposit. Please note that a deposit slip does not contain acceptable banking information. If you have any questions, please call us toll free at 800-842-1718.

\*Please note that not all policies are designed to participate in the Electronic Funds Transfer option. Contact your employee benefits representative or disability plan trustee for details.

2 Employer's Name

Form for Employer's Name, Social Security Number, Primary Phone Number, Control Number, Claim Number, First Name, MI, Last Name.

3 Banking Information

Form for Banking Information including Bank Name, Branch Phone Number, Type of Account (Savings/Checking), Bank Transit Routing Number, Bank Account Number.

4 Payment Plan Agreement

I authorize the Prudential Insurance Company of America to make electronic fund deposits of my disability benefit payment to my account. I understand that any deposit made to an inactive account will be returned to Prudential and reissued as a manual check. In addition, if any overpayment of such disability benefits is credited to my account in error, I authorize Prudential to withdraw any payments necessary in order to assure the accuracy of my claim payments.

I can cancel this authorization at any time by giving Prudential written notice. Any notice hereunder will not be deemed effective until Prudential has received my written notice.

Form for Payment Plan Agreement including Account Owner (First Name, MI, Last Name), Street, Apartment, City, State, ZIP Code, Date Signed, and Signature.





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**5** **Instructions for Completing Section 3, "Banking Information"**

This will help you identify the necessary bank information to initiate electronic withdrawals. The nine-digit transit routing number is how we recognize the bank you do business with.

Record all banking information on page 1 of the form in Section 3, "Banking Information". Please call your bank to confirm that the information you are supplying is correct.

<p><b>Customer XYZ</b>  <b>XYZ Street</b>  <b>City, State, ZIP</b></p>	<p><b>Check No. 1246</b></p>	
<p><b>PAY TO THE ORDER OF</b> _____</p>	<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="text-align: center; width: 40px;">\$</td> </tr> </table> <p><b>Dollars</b></p>	\$
\$		
<p><b>Bank XYZ</b>  <b>UXYZ Street</b>  <b>City, State, ZIP</b></p>		
<p>A27202754                      006666D66666C                      1246</p>		

↑ This is the bank transit routing number. It is always nine digits and appears between the ":" symbols. Record this number in the boxes provided in Section 3, "nine-digit bank transit routing number."

↑ This is your bank account number. It varies in number of digits and may include dashes or spaces. The "<" symbol indicates the end of the account number. Record the account number in the boxes provided in Section 3, "Bank Account Number" and include any dashes and spaces that are within the account number. If there are any digits to the right of the "<" symbol (which do not represent the check sequence number), record them in the boxes provided.

↑ This is the check sequence number. It may be on either end of your check. Please do **not** include this on the authorization form.

*This page consists only of **Instructions**: It is not necessary to return this page with your EFT Authorization.*





The Prudential Insurance Company of America  
Disability Management Services  
P.O. Box 13480, Philadelphia, PA 19176  
Tel: 800-842-1718 Fax: 877-889-4885  
www.prudential.com/mybenefits

Reimbursement Agreement

1 Claimant Information

First Name [grid]

MI [grid]

Last Name [grid]

Claimant Social Security Number [grid]

As an individual covered under a Prudential Group Plan, I have filed a claim for Disability (Short Term Disability and/or Long Term Disability) benefits.

**With respect to Social Security benefits:** I understand that benefits payable under this Group Plan are to be reduced by any benefits under the Social Security Act that I or members of my family receive or would be entitled to receive as a result of my disability, for that same period.

Should my claim for benefits be approved, I request that Prudential postpone making the reduction of benefits described in the second paragraph of this Agreement until I actually am awarded Social Security benefits or complete the Social Security application process described below.

I agree to make timely and diligent pursuit of Social Security benefits through each level of appeal up to and including the Administrative Law Judge level.

These steps may include:

- 1. Application for such benefits;
2. Appeal at the reconsideration level, if benefits are denied;
3. Appeal at the Administrative Law Judge level, if benefits are denied.

I understand that I must provide Prudential with written proof that I have completed the process above. Failure to complete this process and provide proof of same will result in Prudential (1) estimating my monthly Social Security benefits and (2) using that amount to determine my adjusted benefits.

I promise to notify Prudential immediately if I am awarded Social Security benefits.

If any benefits under the Social Security Act are awarded retroactively, I understand and agree that all or a portion of those retroactive Social Security benefits must be immediately repaid to Prudential in accordance with the terms of the Group Plan.

Continued on Page 2





Grid for Social Security Number: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

**With respect to Workers' Compensation or similar coverage:** Unlike the situation described above for Social Security benefits, I understand that regardless of whether or not I sign this Agreement, Prudential will not reduce my Disability Benefits by an estimate of Workers' Compensation (or similar coverage) benefits. Only Workers' Compensation (or similar coverage) benefits actually received by me will be used to determine the benefit I am entitled to receive under this Group Plan.

I agree to repay Prudential immediately the amount paid to me under this Group Plan in excess of the amount to which I would have been entitled under the terms of the Plan if I subsequently receive a Workers' Compensation or similar coverage award.

I hereby assign, transfer and set over to Prudential, to the extent of any excess so paid under this Agreement, the amount of future benefits which may become payable under this Group Plan.

Employee Signature  X

Signature of Witness  X

Name of Employee (Print)  X

Date (MM DD YYYY) [ ][ ] [ ][ ] [ ][ ][ ][ ]

"R/A #1 (Family)"





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Group Disability Insurance Employee Tax Notice

1 Employee Information

Form fields for Employee Information: First Name, MI, Last Name, Social Security Number, Employee Phone Number, E-mail Address, Employer's Name, Control Number.

\*Notice to all parties completing this form: It is fraudulent to fill out this form with information you know to be false or to omit important facts. Criminal and/or civil penalties can result from such acts.

2 Federal and State Withholding

Benefits provided under your Group Disability Income Plan may be subject to federal, state, and local taxation. Contact your employee benefits representative or disability plan trustee for details on your rights and obligations under the various tax codes.

If you wish to have Federal Income Tax (FIT) withheld from any payments you may receive, indicate the amount to be withheld (\$88 monthly minimum for LTD) below and sign the authorization. Withholding requests may also be submitted on IRS Form W-4S. Withholding requests must be stated in whole dollar amounts. FIT will not be withheld if the disability benefit is not taxable.

I request voluntary Federal Income Tax withholding from each payment, as authorized under section 3402(c) of the Internal Revenue Code, in the amount(s) of:

For LTD [ ] .00 monthly (\$88.00 minimum)

3 Employee Signature

X Employee Signature

Date (MM DD YYYY) form fields





## ALTERNATE BENEFIT PROGRAM

### INFORMATION FOR NEW APPLICANTS

A *Carrier Election and Allocation* form must be completed to identify the investment carrier(s) with which you want your contributions invested.

- **If you are eligible for immediate vesting**, the employer contributions become your property immediately upon investment in your account. **You may elect any number of investment carriers and designate the percentage (in whole numbers) of the total contributions they each should receive.**
- **If you are not eligible for immediate vesting**, the employer contributions do not become your property until the beginning of the 13th month of your employment. **You may elect only one investment carrier.**

If you do not file a *Carrier Election and Allocation* form, the ABP Administrator will enroll you with the investment carrier selected as the default carrier for the current plan.

**You must file an application directly with the investment carrier(s) you have elected or with the default investment carrier if you fail to complete this form.** If you fail to do so, you may lose possible revenue from your contributions. Additionally, the carrier(s) you elected will return your contributions to your employer and the ABP administrator will enroll you with the default investment carrier.

### INFORMATION FOR VESTED ABP MEMBERS

ABP members may change their investment carrier election and/or allocation once each quarter of the calendar year.

RETIREE COVERAGE ENROLLMENT APPLICATION
State Health Benefits Program - School Employees' Health Benefits Program
New Jersey Division of Pensions and Benefits
P.O. Box 299 • Trenton, NJ 08625-0299

1. APPLICANT INFORMATION

Social Security Number, Last Name, Title, First Name, Middle Name, Street Address, Apartment #, PO Box, City, State, Zip Code + 4, Date of Birth, Gender, Area Code, Home Telephone Number, Date of Retirement, Status, Former Employer

Were you a part time employee when you retired? Yes No

Table with 3 columns: Question, YES, NO. Rows include Medicare Part A/B, Spouse/Partner Medicare, and child Medicare information.

If your child has Medicare, list child's name and Social Security Number and attach a copy of the Medicare card.

2. TYPE OF ACTIVITY — Submit this application if you are a new enrollee for SHBP or SEHBP Retired Group coverage. Check one box in Section 2; then complete Sections 3 and 4 to select Medical/Dental Coverage.

ENROLLMENT ACTION REQUESTED

New Retiree, New Employer, Survivor Enrollment: Decedent's SS#

3A. MEDICAL COVERAGE (Check one box only).

HORIZON, AETNA options: NJ DIRECT, Aetna Freedom, Horizon HMO, Aetna HMO

For HMO Plans, Enter Primary Care Physician's ID#:

I do not wish to be covered, I wish to waive coverage, I have coverage with another employer, I have coverage with spouse/partner's employer

\*Medicare eligible retirees and dependents cannot enroll in High Deductible Health Plans (HDHP), Aetna Freedom1525, Aetna Freedom2030, or Aetna HMO2030.

To enroll in a High Deductible Health Plan (HDHP), you must complete a Retired Coverage Enrollment Application for High Deductible Health Plan Coverage. For more information visit our Web site at: www.state.nj.us/treasury/pensions

3B. LEVEL OF COVERAGE (Check one box)

Single, Member & Spouse/Civil Union Partner, Family, Parent/Child(ren), Member & Domestic Partner

4A. DENTAL COVERAGE (Check one box only)

I wish to be covered by the Retiree Dental Expense Plan, I do not wish to be covered, I wish to waive coverage, I have coverage with another employer, I have coverage with spouse/partner's employer, List Employer

4B. LEVEL OF COVERAGE (Check one box)

Single, Member & Spouse/Civil Union Partner, Family, Parent/Child(ren), Member & Domestic Partner

4C. PREVIOUS DENTAL COVERAGE

Were you enrolled in a group dental plan for at least 12 months prior to retirement? Yes No, If yes, please provide: Dental Plan Name, Telephone Number, Your Dental Plan ID Number

5. DEPENDENT INFORMATION — List eligible dependents to include for coverage and attach required proof of dependency documents (see instructions on reverse). Attach another sheet of paper for three or more dependents.

Table with columns: Spouse/Partner, Children, Last Name, First Name, MI, Date of Birth, Gender, Social Security Number, Dependent's HMO Primary Care Physician ID#, and dependency status (Natural, Adopted, Foster, Step, Legal Ward)

FOR DIVISION USE ONLY: Event Reason, Effective Date, Waiver Code, Location No., Waiver Codes: 3 - (voluntary) 4 - (non-response) 5 - (spouse) 6 - (employer)

6. I certify that all the information supplied on this form is true to the best of my knowledge. I authorize a pension deduction from my pension check, including initial check, last check benefit, withdrawal check, or return of contributions check as required by the State Health Benefits Commission or School Employees' Health Benefits Commission.

Applicant's Signature, Date, Additional Sheet Attached, Medicare Proof Enclosed

## COMPLETING THE RETIRED COVERAGE ENROLLMENT APPLICATION

Be sure to review Fact Sheet #11, *Enrolling in Health Benefits Coverage When You Retire*, to verify that you are eligible for enrollment into the **State Health Benefits Program (SHBP)** or **School Employees' Health Benefits Program (SEHBP)**.

### SECTION 1 — APPLICANT INFORMATION

This section pertains to the person enrolling in the retired group. Complete all requested information, filling in one letter or number per block. Provide month, day, and year for Date of Birth and Date of Retirement (for example: April 12, 1933 = 04 12 33). Please indicate if you were a part-time employee.

Indicate whether you and/or your spouse/partner and/or child are enrolled in Medicare Parts A and B. Be sure to list the effective dates of the Medicare enrollment. Proof of full Medicare enrollment in Parts A and B is required by the Health Benefits Bureau. Please submit a photo-copy of the Medicare card or a letter from Social Security confirming the effective dates of full Medicare enrollment. Members receiving a Social Security Disability who become Medicare eligible, must be enrolled in the full Medicare program — Part A and Part B — in order to have coverage in the SHBP or SEHBP. If submitting proof of Medicare enrollment, check the box at the bottom right of the application.

### SECTION 2 — TYPE OF ACTIVITY

Check one box in Section 2. If you have applied for retirement or are a new retiree, check the first box "New Retiree".

If you are enrolling as a Surviving Spouse/Partner or Surviving Dependent, check "Survivor Enrollment."

For changes to existing retired group health benefits coverage **DO NOT USE THIS FORM**. To change plans, add or delete dependents, cancel coverage, and make other changes, SHBP or SEHBP members should complete and submit the *Retired Change of Status Application*.

### SECTION 3 — MEDICAL PLAN SELECTION

**NOTE:** Medicare eligible retirees cannot enroll in High Deductible Health Plans (HDHP) or Aetna 2030.

Check only one box indicating either: **1.)** The medical plan into which you want to enroll; or **2.)** That you do not want medical plan coverage (See "Declining or Waiving Coverage" below); or **3.)** That you want to waive medical plan coverage. (See "Declining or Waiving Coverage" below)

When choosing a HMO plan you must list the identification number (ID #) of your Primary Care Physician.

**DECLINING OR WAIVING COVERAGE** — If you are declining coverage and do not want SHBP or SEHBP coverage, check the box indicating that you do not wish to be covered under any of the medical/dental plans.

If you are requesting to waive enrollment for yourself and any of your eligible dependents because of other group health or dental insurance coverage from a public or private employer, check the box indicating that you wish to waive coverage, indicate if the coverage is through your employment or that of your spouse/partner, and the name of the employer. If coverage is waived you may in the future be able to enroll yourself and your eligible dependents in a SHBP or SEHBP medical or dental plan, provided that you request enrollment within 60 days after your other employer group health or dental coverage ends — proof of loss of coverage is required. See Fact Sheet #11, *Enrolling in Health Benefits Coverage When You Retire*, for more information. Police and Firemen's Retirement System (PFRS) members enrolling under Chapter 330, P.L. 1997 should refer to Fact Sheet #47, *Retired Health Benefits Coverage Under Chapter 330*, for more information.

**LEVEL OF COVERAGE** — Select a level of coverage based upon who you will be covering. When you first enroll at the time of retirement, you may add eligible dependents. Your eligible dependents are your spouse or civil union partner, or an eligible same-sex domestic partner, and your children under age 26 (see definitions below).

### SECTION 4 — DENTAL EXPENSE PLAN SELECTION

If eligible, check only one box indicating either: **1.)** that you want to enroll in the Retiree Dental Expense Plan; or **2.)** That you do not want dental coverage (See "Declining or Waiving Coverage" above); or **3.)** That you want to waive dental coverage. (See "Declining or Waiving Coverage" above)

Select a level of coverage based upon who you will be covering. (See "Level of Coverage" above.)

### SECTION 5 — SPOUSE/PARTNER AND CHILDREN

This section is used for members selecting Member & Spouse/Partner, Family, or Parent & Child(ren) coverage. Please list your spouse/partner's name, gender, date of birth, Social Security number, and if enrolling in an HMO plan the spouse/partner's Primary Care Physician Identification Number. Please also list the name, gender, date of birth, Social Security number, and if enrolling in an HMO plan the Primary Care Physician Identification Number for any children you are enrolling. If you are listing more than two children, please provide the required information for your other children on an additional sheet of paper, attach the sheet to the application, and check the box at the bottom right of the application.

**SPOUSE:** This is a person of the opposite sex to whom you are legally married. A photocopy of the *Marriage Certificate* **and** a photocopy of the covered retiree's most recent Federal tax return\* that includes the spouse are required for enrollment.

**CIVIL UNION PARTNER:** This is a person of the same sex with whom you have entered into a civil union. A photocopy of the New Jersey *Civil Union Certificate* or a valid certification from another jurisdiction that recognizes same-sex civil unions **and** a photocopy of the covered retiree's most recent NJ tax return\* that includes the partner are required for enrollment. The cost of civil union partner coverage may be subject to federal tax (see Fact Sheet #75, *Civil Unions*, for details).

**DOMESTIC PARTNER:** This is a same-sex domestic partner, as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act, of any State employee, State retiree, or an eligible employee or retiree of a SHBP or SEHBP participating local public entity if the local governing body adopts a resolution to provide Chapter 246 health benefits. A photocopy of the New Jersey *Certificate of Domestic Partnership* dated prior to February 19, 2007 or a valid certification from another jurisdiction that recognizes same-sex domestic partners **and** a photocopy of the covered retiree's most recent NJ tax return\* that includes the partner are required for enrollment. The cost of same-sex domestic partner coverage may be subject to federal tax (see Fact Sheet #71, *Benefits Under the Domestic Partnership Act*, for details).

\***Note:** On tax forms you may black out all financial information and all but the last 4 digits of any Social Security numbers.

**CHILDREN:** This is your child under age 26. A photocopy of a child's birth certificate showing the name of the retiree as a parent is required for enrollment. If you have listed a child who is an adopted child, foster child, stepchild, legal ward, has a different last name than the employee, or if the member has a Parent/Child contract, additional supporting documentation is required.

**Note:** Dependents may be added later, using the *Retired Change of Status Application*, either within 60 days of the date of event - i.e., marriage, civil union, birth of a child - with an effective date of the date of the event; or added timely with a 60-day waiting period.

### SECTION 6 — CERTIFICATION AND SIGNATURE

The member must read the certification and sign and date the application. If Medicare proof or additional sheets are submitted with the application, check the box indicating such.

**Misrepresentation:** Any person who provides false or misleading information is subject to criminal and civil penalties.

**Return this application and all supporting documentation to:**

NJ DIVISION OF PENSIONS AND BENEFITS  
HEALTH BENEFITS BUREAU  
P.O. BOX 299  
TRENTON, NJ 08625-0299

## REQUIRED DOCUMENTATION FOR SHBP/SEHBP DEPENDENT ELIGIBILITY AND ENROLLMENT

The State Health Benefits Program (SHBP) and School Employees' Health Benefits Program (SEHBP) are required to ensure that only employees, retirees, eligible children, and eligible dependents are receiving health care coverage under the programs. As a result, the Division of Pensions and Benefits must guarantee consistent application of eligibility requirements within the plans. Employees or Retirees who enroll children or dependents for coverage (spouses, civil union partners, domestic partners, children, disabled and/or over age children continuing coverage) must submit the following documentation in addition to the appropriate health benefits enrollment or change of status application.

DEPENDENTS	ELIGIBILITY DEFINITION	DOCUMENTATION REQUIRED
<b>SPOUSE</b>	A person of the opposite sex to whom you are legally married.	A photocopy of the <i>Marriage Certificate</i> <b>and</b> a photocopy of the front page of the employee/retiree's most recently filed federal tax return* ( <i>Form 1040</i> ) that includes the spouse.
<b>CIVIL UNION PARTNER</b>	A person of the same sex with whom you have entered into a civil union.	A photocopy of the <i>New Jersey Civil Union Certificate</i> or a valid certification from another jurisdiction that recognizes same-sex civil unions <b>and</b> a photocopy of the front page of the employee/retiree's most recently filed New Jersey tax return* that includes the partner <b>or</b> a photocopy of a recent (within 90 days of application) bank statement or bill that includes the names of both partners and is received at the same address.
<b>DOMESTIC PARTNER</b>	A person of the same sex with whom you have entered into a domestic partnership. Under Chapter 246, P.L. 2003, the Domestic Partnership Act, health benefits coverage is available to domestic partners of State employees, State retirees, or employees or retirees of a SHBP or SEHBP participating local public entity that has adopted a resolution to provide Chapter 246 health benefits.	A photocopy of the <i>New Jersey Certificate of Domestic Partnership</i> dated prior to February 19, 2007 or a valid certification from another State of foreign jurisdiction that recognizes same-sex domestic partners <b>and</b> a photocopy of the front page of the employee/retiree's most recently filed New Jersey tax return* that includes the partner <b>or</b> a photocopy of a recent (within 90 days of application) bank statement or bill that includes the names of both partners and is received at the same address.
<b>CHILDREN</b>	A subscriber's child until age 26, <i>regardless</i> of the child's marital, student, or financial dependency status – even if the young adult no longer lives with his or her parents.  This includes a stepchild, foster child, legally adopted child, or any child in a guardian-ward relationship upon submitting required supporting documentation.	<b>Natural or Adopted Child</b> – A photocopy of the child's birth certificate — or a photocopy of a National Medical Support Notice (NMSN) if you are the non-custodial parent and are legally required to provide coverage for the child — showing the name of the employee/retiree as a parent.  <b>Step Child</b> – A photocopy of the child's birth certificate showing the name of the employee/retiree's spouse or partner as a parent <b>and</b> a photocopy of the marriage/partnership certificate showing the names of the employee/retiree and spouse/partner.  <b>Legal Guardian, Grandchild, or Foster Child</b> – Photocopies of Final Court Orders with the presiding judge's signature and seal. Documents must attest to the legal guardianship by the covered employee.
<b>DEPENDENT CHILDREN WITH DISABILITIES</b>	If a covered child is not capable of self-support when he or she reaches age 26 due to mental illness or incapacity, or a physical disability, the child may be eligible for a continuance of coverage. Coverage for children with disabilities may continue only while (1) you are covered through the SHBP/SEHBP, and (2) the child continues to be disabled, and (3) the child is unmarried or does not enter into a civil union or domestic partnership, and (4) the child remains substantially dependent on you for support and maintenance. You may be contacted periodically to verify that the child remains eligible for coverage.	Documentation for the appropriate "Child" type (as noted above) <b>and</b> a photocopy of the front page of the employee/retiree's most recently filed federal tax return* ( <i>Form 1040</i> ) that includes the child.  If Social Security disability has been awarded, or is currently pending, please include this information with the documentation that is submitted.  <b>Please note</b> that this information is only verifying the child's eligibility as a dependent. The disability status of the child is determined through a separate process.
<b>CONTINUED COVERAGE FOR OVER AGE CHILDREN</b>	Certain children over age 26 may be eligible for continued coverage until age 31 under the provisions of Chapter 375, P.L. 2005. This includes a child by blood or law who: (1) is under the age of 31; (2) is unmarried or not a partner in a civil union or domestic partnership; (3) has no dependent(s) of his or her own; (4) is a resident of New Jersey or is a student at an accredited public or private institution of higher education, with at least 15 credit hours; and (5) 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.	Documentation for the appropriate "Child" type (as noted above) <b>and</b> a photocopy of the front page of the child's most recently filed federal tax return* ( <i>Form 1040</i> ), <b>and</b> if the child resides outside of the State of New Jersey, documentation of full time student status must be submitted.

**\*Note:** For tax forms you may black out all financial information and all but the last 4 digits of any Social Security numbers.

To obtain copies of the documents listed above, contact the office of the Town Clerk in the city of the birth, marriage, etc., or visit these Web sites: [www.vitalrec.com](http://www.vitalrec.com) or [www.studentclearinghouse.org](http://www.studentclearinghouse.org)  
Residents of New Jersey can obtain records from the State Bureau of Vital Statistics and Registration Web site: [www.state.nj.us/health/vital/index.shtml](http://www.state.nj.us/health/vital/index.shtml)