



State Health Benefits Program (SHBP)  
**HEALTH BENEFITS ACTIVE EMPLOYEE GROUP**  
**WAIVER OF NEW EMPLOYEE WAITING PERIOD FOR SHBP**  
**ENROLLMENT PURSUANT TO EXECUTIVE ORDER NO. 115**

This form is to be completed by the employer and returned with the *Health Benefits Enrollment and/or Change Form* to enroll a new employee for immediate coverage in the State Health Benefits Program (SHBP) pursuant to Executive Order No. 115.

**EMPLOYEE INFORMATION**

Waiver of the 60-day waiting period and enrollment for immediate coverage in the SHBP is requested pursuant to Executive Order No. 115 for the following employee.

- 1. Employee's Name \_\_\_\_\_  
*First* *Last* *MI*
  
- 2. Address \_\_\_\_\_  
*Street* *City* *State* *Zip*
  
- 3. Social Security Number \_\_\_\_\_
  
- 4. Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_
  
- 5. Gender Male  Female
  
- 6. Phone Number \_\_\_\_\_
  
- 7. Email Address \_\_\_\_\_

**EMPLOYER CERTIFICATION**

Employer Name \_\_\_\_\_ Location Number \_\_\_\_\_

I certify that the information provided is true and accurate and that I am subject to prosecution should it be knowingly false.

\_\_\_\_\_  
*Print Certifying Officer Name* *Signature* \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
*Date*

Phone Number \_\_\_\_\_ Ext. \_\_\_\_\_

**Return this completed form to along with the**  
***Health Benefits Enrollment and/or Change Form* to:**  
**New Jersey Division of Pensions & Benefits**  
**Health Benefits Bureau**  
**P.O. Box 299**  
**Trenton, NJ 08625-0299**

You may also scan your completed forms and email with the subject line "SHBP 60 Day Waiver" to [HBclosure@treas.nj.gov](mailto:HBclosure@treas.nj.gov)