Application for Health Coverage & Help Paying Costs

NJ FAMILYCARE
Affordable health coverage. Quality care.

THINGS TO KNOW

Use this application to see what coverage choices you qualify for

- Free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP), known as NJ FamilyCare
- Private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can help pay your premiums for health coverage

Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- If you're single, you may be able to use a short form. Visit njfamilycare.org.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Appendix C.

Apply faster online

Apply faster online at njfamilycare.org.

What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants who need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.** To view the Privacy Act Statement, go to njfamilycare.org.

What happens next?

Send your complete, signed application to the address on page 7. **If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow-up with you within 1–2 weeks. You'll get instructions on the next steps to complete your health coverage. If you don't hear from us, visit njfamilycare.org or call **1-800-701-0710**. Filling out this application doesn't mean you have to buy health coverage.

Get help with this application

- **Online:** njfamilycare.org
- **Phone:** Call our Help Center at **1-800-701-0710.**
- **In person:** There may be counselors in your area who can help. Visit our website or call **1-800-701-0710** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-800-701-0710.**

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STEP 1 Tell us about yourself.

(We need one adult in the family to be the contact person for your application.)

1. First name, Middle name, Last name, & Suffix

2. Home address (Leave blank if you don't have one.) | 3. Apartment or suite number

4. City | 5. State | 6. ZIP code | 7. County

8. Current mailing address (if different from home address) | 9. Apartment or suite number

10. City | 11. State | 12. ZIP code | 13. County

14. Phone number ( ) –

15. Other phone number ( ) –

16. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address: _____

17. What is your preferred spoken or written language (if not English)?

STEP 2 Tell us about your family.

Family Planning (Plan First Program)

If any person on this application is **not eligible** for NJ FamilyCare, would you like them to be evaluated for family planning services (Plan First Program)?

Yes ☐ Check here for all applicants on this application to be evaluated for **family planning services.**

Plan First is a program for women and men that provides only family planning and related services (such as birth control and reproductive health care). Family planning services do not provide minimum essential health care coverage (such as routine care).

Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage).

DO Include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

You DON'T have to include:

- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. **If you have more than 2 people in your family, you'll need to make a copy of the pages and attach them.**

You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

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STEP 2: PERSON 1 (Start with yourself)

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix

2. Relationship to you? **SELF**

3. Date of birth (mm/dd/yyyy) ___ ___ / ___ ___ / ___ ___ ___ ___

4. Sex ☐ Male ☐ Female

5. Citizenship Status: ☐ US citizen or US national ☐ Naturalized or derived citizen (born outside of the US)
If naturalized or derived citizen, enter USCIS #_____ and Certificate # _____
Certificate Type: ☐ Naturalization Certificate ☐ Certificate of Citizenship
If not a citizen, do you have an eligible immigration status? Examples of eligible immigration status are:
• Child under age 21 or pregnant woman: Lawfully residing in the US
• Adult: Lawful Permanent Resident for 5 years OR qualified non-citizen, such as refugee or asylee
☐ Yes, enter information below: ☐ No
Immigration document type_____ Status type (optional)_____
Your name as it appears on immigration document_____
USCIS or I-94 number_____ Card or Passport Number_____
SEVIS ID or expiration date (optional)_____
Other (category code or country of origin)_____
a. Have you lived in the US since 1996? ☐ Yes ☐ No
b. Are you, or your spouse or parent, a veteran or an active-duty member of the US military? ☐ Yes ☐ No

6. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___
If no SSN, have you applied for one? ☐ Yes ☐ No Enter reason: ☐ Not needed for work ☐ Religious reasons ☐ Not eligible

If you have an SSN, providing your SSN and the SSN of other household members can speed up the application process. We use SSNs to check income and other information to see who in your household qualifies for health coverage. If someone wants help getting an SSN, call 1-800-772-1213 (TTY: 1-800-325-0778) or visit socialsecurity.gov. If you do not have an SSN, we will use other documents to process your application.

7a. ☐ **Check this box if you plan to file a federal income tax return NEXT YEAR.**
(You can still apply for health insurance even if you don't file a federal income tax return.)
Will you file jointly with your spouse? ☐ Yes ☐ No
If yes, name of spouse: _____
Will you claim any dependents on your tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____

7b. ☐ **Check this box if you will be claimed as a dependent on someone's federal tax return.**
If yes, please list the name of the tax filer: _____
How are you related to the tax filer? _____

8. Are you pregnant? ☐ Yes ☐ No a. **If yes,** how many babies are expected during this pregnancy? _____ Due Date _____

9. **Do you need health coverage?**
(Even if you have insurance, there might be a program with better coverage or lower costs.)
☐ **YES. If yes**, answer all the questions below.
☐ **NO. If no,** SKIP to the income questions on page 3. Leave the rest of this page blank.

10. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No

11. Do you want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

12. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? ☐ Yes ☐ No

13. Are you a full-time student? ☐ Yes ☐ No

14. Were you in foster care at age 18 or older? ☐ Yes ☐ No

Your answers to questions about race and ethnicity can help us serve the community better. They will not affect if you qualify for coverage or what services you can receive.

15. **Race (Check all that apply)**
☐ Prefer not to answer
☐ White
☐ American Indian or Alaska Native (Complete Appendix B)
☐ Black or African American
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian: _____
☐ Guamanian or Chamorro
☐ Native Hawaiian
☐ Samoan
☐ Other Pacific Islander: _____
☐ Other: _____

16. **Ethnicity (Check all that apply)**
☐ Prefer not to answer
☐ Mexican, Mexican American, Chicano/a
☐ Puerto Rican
☐ Cuban
☐ Another Hispanic, Latino/a, or Spanish origin
☐ Not of Hispanic, Latino/a, or Spanish origin

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STEP 2: PERSON 1 (Continue with yourself)

Current Job & Income Information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 17.

☐ **Not employed**
Skip to question 27.

☐ **Self-employed**
Skip to question 26.

CURRENT JOB 1:

17. Employer name and address

18. Employer phone number
( ) –

19. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

20. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

21. Employer name and address

22. Employer phone number
( ) –

23. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

24. Average hours worked each WEEK

25. **In the past year, did you:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

26. **If self-employed, answer the following questions:**

a. Type of work

_____

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

$ _____

27. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment $ _____ How often? _____

☐ Pensions $ _____ How often? _____

☐ Social Security $ _____ How often? _____

☐ Retirement accounts $ _____ How often? _____

☐ Alimony received $ _____ How often? _____

☐ Net farming/fishing $ _____ How often? _____

☐ Net rental/royalty $ _____ How often? _____

☐ Other income $ _____ How often? _____

Type: _____

28. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 27b).

☐ Alimony paid $ _____ How often? _____

☐ Student loan interest $ _____ How often? _____

☐ Other deductions $ _____ How often? _____

Type: _____

29. **YEARLY INCOME: Complete only if your income changes from month to month.**

If you don't expect changes to your monthly income, skip to the next person.

Your total income **this year**	Your total income **next** year (if you think it will be different)
$	$

THANKS! This is all we need to know about you.

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STEP 2: PERSON 2

If you have more than two people to include, make a copy of Step 2: Person 2 (pages 4 and 5) and complete.

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix | 2. Relationship to you?

3. Date of birth (mm/dd/yyyy) ___ ___ / ___ ___ / ___ ___ ___ ___ | 4. Sex ☐ Male ☐ Female

5. Citizenship Status: ☐ US citizen or US national ☐ Naturalized or derived citizen (born outside of the US)
If naturalized or derived citizen, enter USCIS #_____ and Certificate # _____
Certificate Type: ☐ Naturalization Certificate ☐ Certificate of Citizenship
If not a citizen, does PERSON 2 have an eligible immigration status? Examples of eligible immigration status are:
• Child under age 21 or pregnant woman: Lawfully residing in the US
• Adult: Lawful Permanent Resident for 5 years OR qualified non-citizen, such as refugee or asylee
☐ Yes, enter information below: ☐ No
Immigration document type_____ Status type (optional)_____
PERSON 2 name as it appears on immigration document _____
USCIS or I-94 number_____ Card or Passport Number_____
SEVIS ID or expiration date (optional)_____ Other (category code or country of origin)_____
a. Has PERSON 2 lived in the US since 1996? ☐ Yes ☐ No
b. Is PERSON 2, or PERSON 2's spouse or parent, a veteran or an active-duty member of the US military? ☐ Yes ☐ No

6. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___ **We need this if PERSON 2 wants health coverage and has a SSN.**
If no SSN, has PERSON 2 applied for one? ☐ Yes ☐ No Enter reason: ☐ Not needed for work ☐ Religious reasons ☐ Not eligible
If you have an SSN, providing your SSN and the SSN of other household members can speed up the application process. We use SSNs to check income and other information to see who in your household qualifies for health coverage. If someone wants help getting an SSN, call 1-800-772-1213 (TTY: 1-800-325-0778) or visit socialsecurity.gov. If you do not have an SSN, we will use other documents to process your application.

7. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No
If no, list address: _____

8a. ☐ **Check this box if PERSON 2 plans to file a federal income tax return NEXT YEAR.**
(You can still apply for health insurance even if you don't file a federal income tax return.)
Will PERSON 2 file jointly with their spouse? ☐ Yes ☐ No
If yes, name of spouse: _____
Will PERSON 2 claim any dependents on their tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____

8b. ☐ **Check this box if PERSON 2 plans to be claimed as a dependent on someone's federal tax return.**
If yes, please list the name of the tax filer: _____
How is PERSON 2 related to the tax filer? _____

9. Is PERSON 2 pregnant? ☐ Yes ☐ No a. **If yes,** how many babies are expected during this pregnancy? _____ Due Date _____

10. **Does PERSON 2 need health coverage?** *(Even if they have insurance, there might be a program with better coverage or lower costs.)*

☐ **YES. If yes**, answer all the questions below.

☐ **NO. If no,** SKIP to the income questions on page 5. Leave the rest of this page blank.

11. Does PERSON 2 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No

12. Does PERSON 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

13. Does PERSON 2 live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No

14. Was PERSON 2 in foster care at age 18 or older? ☐ Yes ☐ No

Please answer the following questions if PERSON 2 is 22 or younger:

15. Did PERSON 2 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No
a. **If yes**, end date: _____ b. Reason the insurance ended: _____

16. Is PERSON 2 a full-time student? ☐ Yes ☐ No

Your answers to questions about race and ethnicity can help us serve the community better. They will not affect if you qualify for coverage or what services you can receive.

17. **Race (Check all that apply)**
☐ Prefer not to answer
☐ White
☐ American Indian or Alaska Native (Complete Appendix B)
☐ Black or African American
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian: _____
☐ Guamanian or Chamorro
☐ Native Hawaiian
☐ Samoan
☐ Other Pacific Islander: _____
☐ Other: _____

18. **Ethnicity (Check all that apply)**
☐ Prefer not to answer
☐ Mexican, Mexican American, Chicano/a
☐ Puerto Rican
☐ Cuban
☐ Another Hispanic, Latino/a, or Spanish origin
☐ Not of Hispanic, Latino/a, or Spanish origin

Now, tell us about any income from PERSON 2

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STEP 2: PERSON 2

Current Job & Income Information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 19.

☐ **Not employed**
Skip to question 29.

☐ **Self-employed**
Skip to question 28.

CURRENT JOB 1:

19. Employer name and address

20. Employer phone number
( ) –

21. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

22. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

23. Employer name and address

24. Employer phone number
( ) –

25. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

26. Average hours worked each WEEK

27. **In the past year, did PERSON 2:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

28. **If self-employed, answer the following questions:**

a. Type of work

_____

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

$ _____

29. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment $ _____ How often? _____

☐ Pensions $ _____ How often? _____

☐ Social Security $ _____ How often? _____

☐ Retirement accounts $ _____ How often? _____

☐ Alimony received $ _____ How often? _____

☐ Net farming/fishing $ _____ How often? _____

☐ Net rental/royalty $ _____ How often? _____

☐ Other income $ _____ How often? _____
Type: _____

30. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.

If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 29b).

☐ Alimony paid $ _____ How often? _____

☐ Student loan interest $ _____ How often? _____

☐ Other deductions $ _____ How often? _____
Type: _____

31. **YEARLY INCOME:** **Complete only if PERSON 2's income changes from month to month.**

If you don't expect changes to PERSON 2's monthly income, add another person or skip to the next section.

PERSON 2's total income **this year**	PERSON 2's total income **next year** (if you think it will be different)
$	$

THANKS! This is all we need to know about PERSON 2.

STEP 3 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. **Is anyone enrolled in health coverage now from the following?**

☐ **YES. If yes**, check the type of coverage and write the person(s)' name(s) next to the coverage they have. ☐ **NO.**

☐ Medicaid _____

☐ NJ FamilyCare _____

☐ Medicare _____

☐ TRICARE (Don't check if you have direct care or Line of Duty)

_____

☐ VA health care programs _____

☐ Peace Corps _____

☐ Plan First (Family Planning) _____

☐ Employer insurance _____

Name of health insurance: _____

Policy number: _____

Is this COBRA coverage? ☐ Yes ☐ No

Is this a retiree health plan? ☐ Yes ☐ No

☐ Other

Name of health insurance: _____

Policy number: _____

Is this a limited-benefit plan (like a school accident policy)?

☐ Yes ☐ No

2. **Is anyone listed on this application offered health coverage from a job?** Check yes even if the coverage is from someone else's job, such as a parent or spouse.

☐ **YES. If yes,** you'll need to have your employer complete Appendix A and return to address provided.

☐ **NO. If no, continue to Step 5.**

STEP 4 Select your Health Plan

If you need assistance selecting your Health Plan, contact a Health Benefits Coordinator at 1-800-701-0710, TTY 711.

Choose one:

- ☐ **Aetna Better Health® of New Jersey** (Available in ALL counties)
- ☐ **Amerigroup New Jersey, Inc.** (Available in ALL counties)
- ☐ **Horizon NJ Health** (Available in ALL counties)
- ☐ **UnitedHealthcare Community Plan** (Available in ALL counties)
- ☐ **WellCare Health Plans of New Jersey** (Available in ALL counties, except Hunterdon county)

I understand that if I'm found eligible and because I have joined a Health Plan, I must follow the rules for obtaining health care from the Health Plan. I understand that I must let my Health Plan and NJ FamilyCare know if there is any change in the number of people in my family and that any newborn children will be enrolled in my Health Plan. I understand that, unless I, or a family member, have a true medical emergency, I must call my personal doctor for medical advice, medical care or for a referral to a specialist. I understand that if I, or a family member, have a true medical emergency, I must call my personal doctor or the Health Plan as soon as possible after I, or the family member, go to the hospital. I understand that I must keep any medical appointment I have scheduled with a doctor and, if I cannot, I must call the doctor's office to cancel the appointment. I understand that if I go to a doctor other than my personal doctor I have selected, without a referral from my doctor or approval from the Health Plan, I may have to pay for that doctor's services because NJ FamilyCare will not pay for the unapproved service or visit. I understand that I may change to another Health Plan and that I can call the Health Benefits Coordinator to help me do that. I give permission for the release of my medical history and health care records and those of my family members who will be enrolled to any person(s) in the Health Plan and its providers who shall provide or coordinate health care to me and my family as long as I am a member of the Health Plan.

FOR OFFICE USE ONLY

Name _____ Case # _____

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STEP 5 Read & sign this application.

Applicant and Beneficiary Rights and Responsibilities

Before signing this document, please read the rights and responsibilities outlined below. If there is anything you do not understand or have questions about, please ask for clarification.

- If I am a third party applying on behalf of another person, as evidenced by a completed Designation of Authorized Representative Form, my signature below indicates that this application has been examined by, or read to, the applicant and, to the best of my knowledge, the facts are true and complete. I understand that as a third party, I may be criminally punished for knowingly providing false information.
- I understand that any information I give is subject to verification by the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) for the Medicaid/NJ FamilyCare program, which is called **"NJ FamilyCare"** in this application. I understand that my medical benefits may be reduced, denied, or stopped because of information received through this verification.
- I understand that my situation is subject to verification from employers, financial sources, and other third parties. I hereby give permission to NJ FamilyCare to contact any individual or other source that may have knowledge about my circumstances, or the circumstances of a person necessary for this application, for the purpose of verifying the statements I have made. I give third parties permission to share information about me with authorized State, State contractor, and county staff conducting investigations. Third parties include, but are not limited to, financial institutions, credit reporting agencies, landlords, public housing agencies, schools, utility companies, insurance agencies, employers, other governmental agencies, and others, as necessary. I further authorize taxing authorities to release my tax information and copies of my tax returns.
- I understand that DHS, including its operating Divisions, eligibility determining agencies, government contractors, and other appropriate State of New Jersey agencies, may exchange information relating to coverage to assist with this application, enrollment, administration, and billing services.
- I understand that DMAHS has the authority to file a claim and lien against the estate of a deceased Medicaid beneficiary, or former beneficiary, to recover all NJ FamilyCare payments made on the beneficiary's behalf to pay for health care coverage on or after age 55, regardless of whether services were received. An NJ FamilyCare beneficiary's estate may be required to pay back DMAHS for those benefits. This includes monthly payments to, for example, a managed care entity to secure health care coverage that you may not use in any month. More information about Estate Recovery is available online at: www.state.nj.us/humanservices/dmahs/clients/The_NJ_Medicaid_Program_and_Estate_ Recovery_What_You_Should_Know.pdf
- I agree to tell the eligibility determining agency immediately of changes to information entered on this application including, but not limited to, the following:
    1) If anyone receiving health benefits moves out of New Jersey;
    2) Changes in where we live, get our mail, or any other contact information;
    3) Changes in other health insurance coverage;
    4) Changes in income and/or resources;
    5) Improvement in medical condition, if disabled;
    6) Marriage, divorce, or death of a spouse;
    7) Addition or loss of household member, including pregnancy;
    8) Sale or transfer of my home or other property; or,
    9) Lawsuits and inheritances.

I understand that failure to report changes in application information, including those changes listed above, may result in incorrectly paid benefits/coverage, and I may have to reimburse the State of New Jersey for those benefits/coverage.

- I understand that the outcome of this application may be shared with any provider who provided services to the applicant/beneficiary during the period covered by the application.
- I understand, as a condition of being covered under Medicaid/NJ FamilyCare, that I have assigned to the Commissioner of the Department of Human Services any rights to support for the purpose of medical care as determined by a court or administrative order and any rights to payment for medical care from a third party including, but not limited to, other health insurance, legal settlements, or other third parties. I agree to release any medical information needed by the NJ FamilyCare program, or others, for the purpose of paying or receiving payment of medical bills. I agree to help in obtaining medical support and payments from anyone who is legally responsible.
- I understand that I may request a fair hearing if I am not satisfied with the determination of my application.

I may be eligible for retroactive NJ FamilyCare coverage for unpaid, covered medical services by Medicaid Fee-for-Service providers during the three (3) months prior to this application. I further understand that these retroactive benefits will only apply to the month(s) that eligibility requirements are met.

- I understand that an individual is only permitted to retain a certain amount in resources, depending on the program's eligibility requirements. I understand that if I am seeking Long Term Services and Supports or services based on an institutional level of care, NJ FamilyCare will examine transfers of resources that occurred within the 5 year look-back period before, and any time after, my first date of applying for benefits.

Step 6 - Applicant and Beneficiary Rights and Responsibilities

- In order to redetermine my eligibility for NJ FamilyCare in the future, I agree to allow NJ FamilyCare to use income data, including tax information. At time of renewal, NJ FamilyCare will send me a renewal notice and let me indicate any changes in my or my household's eligibility information, and I can withdraw my request for benefits in writing at any time.
- I understand that if some or all of the individuals applying do not qualify for NJ FamilyCare health care coverage, that they may be eligible for federal benefits and/or may explore private health care coverage options through the State of New Jersey's Health Insurance Marketplace (Marketplace) at GetCovered.NJ.gov.

If this is the case, I authorize NJ FamilyCare and its contractors to give information contained in this application to the Marketplace.

- I confirm that I have read and understood the NJ FamilyCare Privacy Policy available online at: https://njfc.force.com/familycare/NJPrivacyNotice and the Notice of Privacy Practices available online at: www.njfamilycare.org/docs/NJFC-HIPAA.pdf
- I understand that NJ FamilyCare may use or disclose protected health information about me or my children if State or federal privacy laws require or allow it.
- I authorize my employer to release health benefits information to the NJ FamilyCare Office of Premium Support.
- I will obey the law and regulations of NJ FamilyCare.
- I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, or disability. I can get more information, including how to file a complaint of discrimination, by reading the NJ FamilyCare Non-Discrimination Statement available online at: www.njfamilycare.org/docs/ndc_english.pdf

NOTE: The submission of a Social Security number (SSN) is mandatory in accordance with 42 U.S.C. 1320b-7. The SSNs provided (including for a husband or wife, family members, or dependents) will be used to associate records pertaining to applicants and other persons necessary for the determination of eligibility, to verify identity, to verify income, and to check other financial records, such as bank account information, to the extent it is useful in verifying eligibility or the amount of medical assistance payments under 42 CFR 435.940 through 435.960 and to prevent duplicate participation or incorrectly paid benefits for you and for persons in your household. The SSNs will be used in computer matching and program reviews or audits. These procedures are designed to determine eligibility and to identify persons who fraudulently or wrongfully participate in Medicaid and DHS programs. Such persons may be subjected to criminal action, administrative claims, and/or possible loss of all benefits. Failure to file for a SSN may result in disqualification for Medicaid.

NJ FamilyCare complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, sex, age or disability. **If you speak any other language, language assistance services are available at no cost to you.** Call 1-800-701-0710 (TTY:711).

Applicant Signature

The person who filled out this application must sign this application. If you're an authorized representative, you may sign here, as long as you have provided the Designation of Authorized Representative Form.

By signing below, I certify under penalty of perjury and false swearing that my answers on this application are true, correct, and complete to the best of my knowledge. I also certify that:

- I understand the questions and statements on this application.
- I understand that I may be subject to penalties under federal and State law if I provide false or untrue information.

By signing below I also certify that I have read and understand the Applicant and Beneficiary Rights and Responsibilities included.

Applicant's Signature	Date (mm/dd/yyyy)
Authorized Representative Name	Relationship
Authorized Representative Signature	Date (mm/dd/yyyy)

This application cannot be considered until it is received by the Eligibility Determining Agency.

STEP 6 Mail Completed Application.

Mail your signed application to:

NJ FamilyCare
PO BOX 8367
TRENTON, NJ 08650-9802

NJFC-APP-E-1222

APPENDIX A

NJFAMILYCARE
Affordable health coverage. Quality care.

Health Coverage from Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the **job** that offers coverage.

You need to include this page when you send in your application.

EMPLOYEE Information

1. Employee name (First, Middle, Last)	2. Employee Social Security number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

EMPLOYER Information

3. Employer name	4. Employer Identification Number (EIN) ___ ___ - ___ ___ ___ ___ ___ ___ ___
5. Employer address	6. Employer phone number ( ) –

7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		

11. Phone number (if different from above) ( ) –	12. Email address

13. **Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

☐ **No** (Stop here and go to Step 5 in the application)

Tell us about the **health plan** offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? **$** _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? **$** _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy): _____

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

NEED HELP WITH YOUR APPLICATION? Visit njfamilycare.org or call us at **1-800-701-0710**. Para obtener una copia de este formulario en Español, llame **1-800-701-0710**. If you need help in a language other than English, call **1-800-701-0710** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **711.**

APPENDIX B

NJFAMILYCARE
Affordable health coverage. Quality care.

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your NJ FamilyCare Application for Health Coverage & Help Paying Costs.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1	AI/AN PERSON 2
1. Name (First name, Middle name, Last name)	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐ Yes **If yes**, tribe name _____ ☐ No	☐ Yes **If yes**, tribe name _____ ☐ No
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	☐ Yes ☐ No **If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No **If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No
4. Certain money received may not be counted for NJ FamilyCare. List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance	**$** _____ How often?_____	**$** _____ How often?_____

NEED HELP WITH YOUR APPLICATION? Visit **njfamilycare.org** or call us at **1-800-701-0710**. Para obtener una copia de este formulario en Español, llame **1-800-701-0710**. If you need help in a language other than English, call **1-800-701-0710** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **711.**

APPENDIX C

NJ FAMILYCARE
Affordable health coverage. Quality care.

Assistance with Completing this Application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact NJ FamilyCare. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)		
2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number ( ) –		
8. Organization name		9. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

10. Your signature	11. Date (mm/dd/yyyy)

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)	
2. First name, Middle name, Last name, & Suffix	
3. Organization name	4. ID number (if applicable)

NEED HELP WITH YOUR APPLICATION? Visit **njfamilycare.org** or call us at **1-800-701-0710**. Para obtener una copia de este formulario en Español, llame **1-800-701-0710**. If you need help in a language other than English, call **1-800-701-0710** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **711.**

NJ FAMILYCARE
Affordable health coverage. Quality care.

STATE OF NEW JERSEY
Department of Human Services
Division of Medical Assistance and Health Services

Non-Discrimination Statement

Discrimination is Against the Law

NJ FamilyCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, sex, age or disability. NJ FamilyCare does not exclude people or treat them differently because of race, color, national origin, sex, age or disability.

NJ FamilyCare:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please contact 1-800-701-0710 (TTY: 711).

If you believe that NJ FamilyCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, sex, age or disability, you can file a grievance with the NJ FamilyCare Civil Rights Coordinator via the following: NJ Civil Rights Coordinator, NJ Department of Human Services, Office of Legal and Regulatory Affairs, P.O. Box 700, Trenton, NJ 08625-0700, 1-888-347-5345 or email: DHS-CO.OLRA@dhs.state.nj.us. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also electronically file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
SW, Room 509F, HHH Building
200 Independence Avenue
Washington, D.C. 20201

1-800-368-1019, 1-800-537-7697 (TDD)

U.S. Department of Health and Human Services complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

If you speak any other language, language assistance services are available at no cost to you. Call 1-800-701-0710 (TTY: 711).

New Jersey Non-Discrimination Statement

NJ FamilyCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, sex, age or disability. If you speak **any other language,** language assistance services are available at no cost to you. Call 1-800-701-0710 (TTY: 711).

Spanish. NJ FamilyCare cumple con las leyes federales de derechos civiles correspondientes y no discrimina con base en la raza, el color, la nacionalidad, el sexo, la edad o la discapacidad. Si usted habla **español**, tiene a su disposición los servicios de asistencia con el idioma sin costo alguno. Llame al 1-800-701-0710 (TTY: 711).

Chinese. NJ FamilyCare 遵守适用的联邦人权法律，不会因为种族、肤色、原国籍、性别、年龄或残障而进行歧视。如果您讲中文，您可免费获得语言协助服务。请致电 1-800-701-0710 (TTY: 711）。

Korean. NJ FamilyCare는 적용되는 연방 민권법을 준수하며 인종, 피부색, 출신 국가, 성별, 나이 또는 장애 여부에 따라 차별을 하지 않습니다. **한국어**를 쓰시는 경우, 언어 지원 서비스가 무료로 제공됩니다. 1-800-701-0710 (TTY: 711)으로 문의해 주십시오.

Portuguese. O NJ FamilyCare cumpre as leis federais aplicáveis de direitos civis e não discrimina com base em raça, cor, origem nacional, sexo, idade ou deficiência. Se você fala **português**, serviços linguísticos gratuitos estão à sua disposição. Ligue para 1-800-701-0710 (TTY: 711).

Gujarati. NJ FamilyCare, લાગુ પડતાં ફેડરલ નાગરિક અધિકાર કાયદાઓનું પાલન કરે છે અને જાતિ, રંગ, રાષ્ટ્રીય મૂળ, લિંગ, વય અથવા અપંગતાને આધારે ભેદભાવ કરતું નથી. જો તમે **ગુજરાતી** બોલતા હોવ તો ભાષા સહાય સેવાઓ તમારે માટે નિ:શુલ્ક ઉપલબ્ધ છે. ફોન કરો 1-800-701-0710 (TTY: 711).

Polish. NJ FamilyCare przestrzega wszelkich obowiązujących przepisów federalnych dotyczących praw człowieka i nie dopuszcza się dyskryminacji ze względu na rasę, kolor skóry, pochodzenie narodowe, płeć, wiek lub niepełnosprawność. Dla osób mówiących po **polsku** dostępna jest bezpłatna pomoc językowa. Prosimy zadzwonić pod numer 1-800-701-0710 (TTY: 711).

Italian. NJ FamilyCare si attiene a tutte le leggi federali per i diritti civili e non discrimina sulla base di etnia, colore, nazionalità, genere, età o disabilità. Se lei parla **Italiano,** sono a sua disposizione servizi gratuiti nella sua lingua. Chiami il numero 1-800-701-0710 (TTY: 711).

Arabic. تلتزم NJ FamilyCare بقوانين الحقوق المدنية السارية ولا تميز على أساس العرق أو اللون أو الأصل القومي أو الجنس أو السن أو الإعاقة. إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية دون تحملك أي تكلفة. اتصل بالرقم 1-800-701-0710 (TTY: 711).

Tagalog. Ang NJ FamilyCare ay tumutupad sa mga angkop na Pederal na batas ukol sa mga sibil na karapatan at hindi ito nagdidiskrimina batay sa lahi, kulay, bansang pinanggalingan, kasarian, edad, o kapansanan. Kung nagsasalita ka ng **Tagalog**, makakakuha ka ng walang bayad na serbisyo ng tulong sa wika. Tumawag sa 1-800-701-0710 (TTY: 711).

Russian. Программа NJ FamilyCare действует в соответствии с федеральным законодательством о гражданских правах и не дискриминирует на основе расовой принадлежности, цвета кожи, национального происхождения, пола, возраста или инвалидности. Если вы говорите **по-русски,** то можете получить бесплатную языковую поддержку. Позвоните по номеру телефона 1-800-701-0710 (TTY: 711).

French Creole (Haitian Creole). NJ FamilyCare obeyi lwa federal konsènan dwa sivil e li pa diskrimine nonplis selon ras yo, koulè po yo, peyi kote yo soti, sèks, laj, oswa poutèt yo endikape. Si w pale **kreyòl**, gen sèvis asistans lang disponib pou w gratis. Rele nan 1-800-701-0710 (TTY : 711).

Hindi. NJ FamilyCare, लागू संघीय मानव अधिकार कानूनों का अनुपालन करता है और जाति, रंग, राष्ट्रीय मूल, लिंग, उम्र या विकलांगता के आधार पर भेदभाव नहीं करता है। यदि आप हिन्दी बोलते हैं तो, आपको भाषा सहायता सेवाएँ नि: शुल्क उपलब्ध हैं। 1-800-701-0710 (TTY: 711) पर कॉल करें।

Vietnamese. NJ FamilyCare tuân thủ theo luật dân quyền Liên Bang hiện hành và không kỳ thị dựa trên chủng tộc, màu da, nguồn gốc quốc gia, giới tính, độ tuổi hoặc khuyết tật. Nếu quý vị nói **Tiếng Việt,** hiện có các dịch vụ trợ giúp về ngôn ngữ miễn phí cho quý vị. Gọi số 1-800-701-0710 (TTY: 711).

French. NJ FamilyCare respecte les lois applicables aux États-Unis en matière de droits civiques et ne pratique aucune discrimination fondée sur la race, la couleur, l'origine nationale, le sexe, l'âge ou le handicap. Si vous parlez le **français,** vous pouvez bénéficier de services d'assistance linguistique gratuits. Appelez le 1-800-701-0710 (TTY : 711).

Urdu. NJ FamilyCare قابل اطلاق وفاقی شہری حقوق کے قوانین کی پابندی کرتا ہے اور نسل، رنگ، قومی نژاد، جنس، عمر یا معذوری کی بنیاد پر امتیاز نہیں برتتا۔ اگر آپ **اردو** بولتے ہیں تو زبان سے متعلق مدد کی خدمات آپ کے لیے مفت دستیاب ہیں۔ کال کیجیے 1-800-701-0710 (TTY: 711)۔

State of New Jersey
Department of State
Division of Elections

Voter Registration Opportunity

The National Voter Registration Act of 1993 requires the State to provide you with the opportunity to register to vote as an additional service offered by this office. Please complete the form below to advise the agent of your interest to register or not to register to vote at this time.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you decline to register to vote at this time, your decision will remain confidential and will be used only for voter registration purposes. If you do register to vote, the way in which you do so will remain confidential and will be used only for voter registration purposes.

You can register to vote if:

- You are a United States citizen
- You will be 18 years of age by the next election
- You will be a resident of the State and county 30 days before the election
- You are NOT currently serving a sentence, probation or parole because of a felony conviction

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with: the NJ Division of Elections, (mailing address) P.O. Box 304, Trenton, NJ 08625-0304; (office location) 225 West State Street, 5th Floor, Trenton, NJ 08608; telephone 609-292-3760, fax number 609-777-1280, TTY 1-800-292-0034, Elections.NJ.gov.

If you would like help in filling out the voter registration application form, we will help you. You can call NJ FamilyCare at 1-800-356-1561. The decision whether to seek or accept help is yours. You may fill out the application form in private.

This section can be returned to NJ FamilyCare at: NVRA Liaison, PO 712, Trenton, NJ 08625-0712

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

❑ Yes ❑ No ❑ I am already registered

IF YOU DO NOT CHECK A BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

Print Name _____ Signature _____ Date _____

For Official Use

RTS ☐

_____Initial

New Jersey
Voter Registration Application

Please print clearly in ink. All information is required unless marked optional.

1 Check boxes that apply: ☐ New Registration ☐ Address Change ☐ Political Party Affiliation ☐ Name Change ☐ Signature Update or Non-affiliation Change

FOR OFFICIAL USE ONLY

Clerk

Registration #

Office Time Stamp

☐ by mail
☐ in person

2 Are you a U.S. Citizen? ☐ Yes ☐ No *(If No, DO NOT complete this form)*

Are you at least 17 years of age? ☐ Yes ☐ No *(If No, DO NOT complete this form)*

3 Last Name | First Name | Middle Name or Initial | Suffix *(Jr., Sr., III)*

4 Date of Birth

5 NJ Driver's License Number or MVC Non-driver ID Number

__ __ __ __ __ __ __ __ __ __ __ __ __ __ __

If you DO NOT have a NJ Driver's License or MVC Non-Driver ID, provide the last 4 digits of your Social Security Number. ___ ___ ___ ___

☐ "I swear or affirm that I DO NOT have a NJ Driver's License, MVC Non-driver ID or a Social Security Number."

		Apt.	Municipality	County	State	Zip Code
6	Home Address *(DO NOT use PO Box)*					
7	Mailing Address if different from above					
8	Last Address Registered to Vote *(DO NOT use PO Box)*					

9 Former Name if Making Name Change

a. Day Phone Number *(Optional)* _____

b. E-Mail Address *(Optional)* _____

10 Do you wish to declare a political party affiliation? *(Optional)* ☐ Yes, the party name is _____. ☐ No, I do not wish to be affiliated with any political party.

11 Gender
☐ Female
☐ Male

Declaration - I swear or affirm that:
- I am a U.S. Citizen
- I live at the above address
- I am at least 17 years old, and understand that I may not vote until reaching the age of 18.
- I will have resided in the State and county at least 30 days before the next election
- I am not on parole, probation or serving a sentence due to a conviction for an indictable offense under any federal or state laws
- I understand that any false or fraudulent registration may subject me to a fine of up to $15,000, imprisonment up to 5 years, or both pursuant to R.S. 19:34-1

Signature: Sign or mark and date on lines below

x _____ Date _____

If applicant is unable to complete this form, print the name and address of individual who completed this form.

Name _____

Date _____

Address _____

Important Instructions for sections 5, 6 and 10

5) Registrants who are submitting this form by mail and are registering to vote for the first time: If you do not have any of the information required by section 5, or the information you provide cannot be verified, you will be asked to provide a COPY of a current and valid photo ID, or a document with your name and current address on it to avoid having to provide identification at the polling place.

Note: *ID Numbers are Confidential and will not be released by any governmental agency. Any person who uses such numbers illegally shall be subject to criminal penalties.*

6) If you are homeless, you may complete section 6 by providing a contact point or the location where you spend most of your time.

10) You may declare a political party affiliation or you may declare to be unaffiliated, regardless of any prior party affiliation. If you are a previously affiliated voter who wants to change political party affiliation or become unaffiliated, you must file this form no later than 55 days before the primary election in order to vote in the primary election. Completing section 10 is OPTIONAL and will not affect the acceptance of your voter registration application.

Need More Information? Check boxes below if you would like to receive more information about:

☐ voting by mail
☐ becoming a poll worker
☐ polling place accessibility
☐ voting if you have a disability, including visual impairment
☐ available election materials in this alternative language: _____

For further information visit **Elections.NJ.gov** or call toll-free **1-877-NJVOTER** (1-877-658-6837)

New Jersey
Voter Registration Information

You can register to vote if:

- You are a United States citizen.
- You are at least 17 years of age.*
- You will be a resident of the State and county 30 days before the election.
- You are **NOT** currently serving a sentence, probation or parole because of a felony conviction.

**You may register to vote if you are at least 17 years old but cannot vote until reaching the age of 18.*

Registration Deadline: 21 days before an election

Your County Commissioner of Registration will notify you if your application is accepted.
If it is not accepted, you will be notified on how to complete and/or correct the application.

Questions? visit Elections.NJ.gov or call toll-free 1-877-NJVOTER (1-877-658-6837)

1 FOLD

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

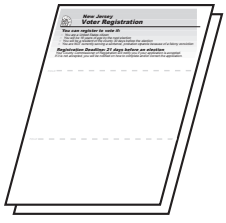
BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 206 TRENTON, NJ

POSTAGE WILL BE PAID BY ADDRESSEE

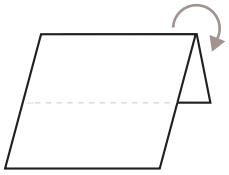
DIVISION OF ELECTIONS
PO BOX 304
TRENTON NJ 08625-9983

2 FOLD

Important: Print out at 100% - DO NOT REDUCE. Fold as illustrated to ensure proper mailing.

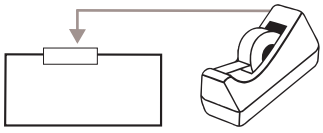


Put both pages together as shown



1 fold top down

2 fold bottom up



3 Tape top shut

3 TAPE HERE