State Health Benefits Program (SHBP)
School Employees' Health Benefits Program (SEHBP)

RESOLUTION

A Resolution to Authorize a Change in the Average Number of Hours of Employment per Week Required for Full-Time Status for Participation in the SHBP/SEHBP in Accordance With N.J.S.A. 52:14-17.26 and N.J.S.A. 52:14-17.46.2.

BE IT RESOLVED:

1. The _____ _____ ,
   Corporate Name of Employer *SHBP/SHEBP Employer Location Number*

   a participating employer in the SHBP/SEHBP, hereby designates _____* hours per week (average) as the minimum requirement for full-time status in accordance with N.J.S.A. 52:14-17.26 and N.J.S.A. 52:14-17.46.2.

   **May not be less than 25 hours per week for employees, or less than 35 hours per week for elected or appointed officials.*

2. This change in the number of hours of employment required for SHBP/SEHBP eligibility applies to: (check one)

   ☐ **All Employees** — We will inform employees currently enrolled in the SHBP and/or SEHBP who do not work the minimum number of hours per week required to participate in the Program of this change and their termination from coverage. We will distribute Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) notices to these employees via the Employer Pensions and Benefits Information Connection (EPIC) and complete the *Transmittal of Deletions* to terminate affected employees from coverage. We understand termination of coverage will occur thereafter in accordance with the statutes and regulations of the SHBP and/or SEHBP.

   ☐ **Employees Hired After** ____/____/_____
   mm dd yyyy

   Current employees eligible for participation in the SHBP and/or SEHBP under the previous full-time hours of employer definition will be permitted to continue coverage in the Program. The new designation of minimum number of hours worked per week for full-time status as designated in Section 1 will not apply to employees hired prior to June 1, 2010, as long as there is no break in service.

3. This resolution shall take effect immediately and the change in full-time hours shall be effective as of

   ____/____/_____(allow over 60 days) or as soon thereafter as it may be effectuated pursuant to the statutes and regulations.
   mm dd yyyy

I hereby certify that the foregoing is a true and correct copy of a resolution duly adopted by the:

_____ ____/____/_____
Corporate Name of Employer *mm dd yyyy*

_____
Street Address *City* *State* *Zip Code*

_____
Area Code *Telephone Number*

_____ _____
Signature *Official Title*

_____ _____
Number of Employees *Employer's State Employer Identification Number (EIN)*

Mail Completed Resolution to:

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