



## RESOLUTION

### A Resolution to Authorize Participation Under the SHBP and/or SEHBP.

BE IT RESOLVED:

1. The \_\_\_\_\_  
*Corporate Name of Employer* \_\_\_\_\_  
*SHBP/SHEBP Employer Location Number*  
hereby elects to participate in the Health Program provided by the New Jersey State Health Benefits Act of the State of New Jersey (N.J.S.A. 52:14-17.26 and N.J.S.A. 52:14-17.46.2) and to authorize coverage for all the employees and their dependents thereunder in accordance with the statute and regulations adopted by the State Health Benefits Commission and/or School Employees' Health Benefits Commission.
2. a.  We elect to participate in the Employee Prescription Drug Plan defined by N.J.S.A. 52:14-17.25 et seq. and authorize coverage for all employees and their dependents in accordance with the statute and regulations adopted by the State Health Benefits Commission and/or School Employees' Health Benefits Commission.
- b.  We will be maintaining \_\_\_\_\_  
*Name of Plan* as our Prescription Drug Plan.<sup>1</sup> This plan is comparable in design to the State Employee Prescription Drug Plan.
- c.  We will not have a stand-alone prescription drug plan and understand that prescription drug coverage will be provided based on the medical plan chosen by the subscriber.
3. a.  We elect to participate in the Employee Dental Plans defined by N.J.S.A. 52:14-17.25 et seq. and authorize coverage for all employees and their dependents in accordance with the statute and regulations adopted by the State Health Benefits Commission and/or School Employees' Health Benefits Commission.
- b.  We will be maintaining \_\_\_\_\_  
*Name of Plan* as our dental plan.<sup>1</sup>
- c.  We will not have a dental plan.
4. We elect \_\_\_\_\_<sup>2</sup> hours per week (average) as the minimum requirement for full-time status in accordance with N.J.A.C. 17:9-4.6.
5. As a participating employer we will remit to the State Treasury all charges due on account of employee and dependent coverage and periodic charges in accordance with the requirements of the statute and the rules and regulations duly promulgated thereunder.
6. We hereby appoint \_\_\_\_\_  
*Name/Title* to act as Certifying Officer in the administration of this program.

**Note:** An individual is permitted coverage as an employee, retiree, or dependent. Multiple coverage under the SHBP or SEHBP is prohibited.

<sup>1</sup> If not electing prescription drug coverage and/or dental plan participation through the SHBP or SEHBP, attach copies of the current prescription drug and dental plan contracts.

<sup>2</sup> May not be less than 25 hours per week for employees, or 35 hours per week for elected or appointed officials.

*Please complete page 2 of this form.*



**RESOLUTION**

*Continued from page 1.*

7. This resolution shall take effect immediately and coverage shall be effective as of     /    /     or as soon thereafter as it may be effectuated pursuant to the statutes and regulations (can be no less than 75 or 90 days pursuant to the provisions of N.J.S.A. 17:9-1.4).

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**