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

RESOLUTION

A Resolution to Authorize Participation in the SHBP/SEHBP for Dental Plan Coverage.

BE IT RESOLVED:

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

   a participating employer in the SHBP/SEHBP, hereby elects to participate in the Employee Dental Plans provided by the New Jersey State Health Benefits Act of the State of New Jersey (N.J.S.A. 52:14-17.25 et seq.) 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.

2. 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.

3. As the employer, I understand that the employer is responsible for at least 50 percent of the dental premium.

4. We hereby appoint _____ to act as Certifying Officer in the administration of this program.
   Name/Title

5. 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.
   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)* *Present Dental Plan Carrier*

Mail Completed Resolution to:

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