



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

**A Resolution to Adopt the Provisions of Chapter 48 (N.J.S.A. 52:14.17.38) Under Which a Public Employer May Agree to Pay for the SHBP and/or SEHBP Coverage of Certain Retirees.**

BE IT RESOLVED:

1. The \_\_\_\_\_  
*Corporate Name of Employer* \_\_\_\_\_  
*SHBP/SHEBP Employer Location Number*

hereby elects to adopt the provisions of N.J.S.A. 52:14-17.38 and adhere to the rules and regulations promulgated by the State Health Benefits Commission and School Employees' Health Benefits Commission to implement the provisions of that law.

2. This resolution affects employees as shown on the attached *Chapter 48 Resolution Addendum*. It is effective on the 1st day of \_\_\_\_\_, \_\_\_\_\_.  
*Month* , *Year*

3. We are aware that adoption of this resolution does not free us of the obligation to pay for post-retirement medical benefits of retirees or employees who qualified for those payments under any *Chapter 88 Resolution* or *Chapter 48 Resolution* adopted previously by this governing body.

4. We agree that this resolution will remain in effect until properly amended or revoked with the SHBP and/or SEHBP. We recognize that while we participate with the SHBP and/or SEHBP, we are responsible for providing the payment for post-retirement medical coverage as listed in the attached *Chapter 48 Resolution Addendum* for all employees who qualify for this coverage while this resolution is in force.

5. We understand that we are required to provide the New Jersey Division of Pensions & Benefits (NJDPB) complete copies of all contracts, ordinances, and resolutions that detail post-retirement medical payment obligations we undertake. We also recognize that we may be required to provide the NJDPB with information needed to carry out the terms of this resolution.

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**



State Health Benefits Program (SHBP) and School Employees' Health Benefits Program (SEHBP)  
**CHAPTER 48 RESOLUTION ADDENDUM**

**Please read instructions on reverse side before completing this form.**

Effective Date of Resolution mm / dd / yyyy Form to be used for: Medical  Dental  Both

Employer Name \_\_\_\_\_  
Corporate Name of Employer, SHBP/SEHBP Employer Location Number \_\_\_\_\_

CLASS OF EMPLOYEES Examples: police officers, clerical workers, bargaining unit (PBA, CWA), nonaligned, or individual(s)	N.J.S.A. 52:14-17.38 Provisions Adopted						Premium Payment Retirees If Yes Show %	Premium Payment Dependents If Yes Show %	Medicare Reimbursement If Yes Show %	Premium Payment Surviving Spouses If Yes Show %	Do Benefits Apply to Current Retirees		If Benefits do Not Apply to Current Retirees, Give Effective Date
	1) Retired on a Disability Retirement	2) Retired w/25 or + years of service	2a) Number of years service w/employer	3) Retired age 65 + w/25 years service	3a) Number of years service w/employer	4) Retired 62 or older w/15 years or more service w/employer					No	Yes	

**Note:** An age requirement is not permitted on Option 1 or 2; Option 3 and 4 already have an age requirement.