HR-1008-0318

State of New Jersey • Department of the Treasury

DIVISION OF PENSIONS & BENEFITS — HEALTH BENEFITS SECTION

P.O. Box 295, Trenton, NJ 08625-0295

P.L. 1997, c. 330 (CHAPTER 330) — EMPLOYER CERTIFICATION FOR HEALTH BENEFITS

TO BE COMPLETED BY THE EMPLOYER

Retiree's Name _____ SSN _____

Employer Name _____ Employer # _____

I certify that the above-stated retiree was a full-time employee, and based on the union contract in effect as of July 1,1998:

_____ Is eligible for employer-paid health benefits in retirement or receives reimbursement for health benefits premiums, in full or in part, for his/her lifetime.

_____ Is not eligible for employer-paid health benefits in retirement and will not receive employer-paid reimbursement for health benefits premiums.

_____ Is eligible for health benefits in retirement for a specified, limited time. Health benefits will terminate upon:

____ Retiree becoming eligible for Medicare

____ Other — *specify reason and give date that health benefits will terminate* _____

_____

Certifying Officer's Signature _____ Date _____

Certifying Officer's Name (please print) _____

Telephone Number _____

PLEASE RETURN THIS FORM TO: STATE HEALTH BENEFITS PROGRAM
RETIRED HEALTH BENEFITS SECTION
P.O. BOX 299
TRENTON, NJ 08625-0299
OR FAX IT TO:
(609) 341-3407