



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

To be completed by the employing agency's Certifying Officer.

A resolution to terminate participation under the SHBP/SEHBP for prescription drug coverage only.

BE IT RESOLVED:

1. The _____
Name of Employer _____ *SHBP/SEHBP Employer Location Number*
hereby resolves to terminate its participation in the State Employee Prescription Drug Plan thereby canceling prescription drug coverage provided by the SHBP/SEHBP (N.J.S.A. 52:14-17.25 et seq.) for all its active employees.
2. We shall notify all active employees of the date of their termination of coverage under the Program.
3. We understand that all participants in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) will be notified by the New Jersey Division of Pensions & Benefits and advised to contact our office concerning a possible alternative prescription drug program.
4. We understand that this resolution shall take effect the first of the month following a 60-day period beginning with the receipt of the resolution by the State Health Benefits Commission (SHBC) or the School Employees' Health Benefits Commission (SEHBC).
5. We understand that this plan must be comparable in design, as determined by the Commission, to the State Employee Prescription Drug Plan.

Please complete and comply with the following:

New Prescription Drug Carrier _____

Reason for termination of the State Employee Prescription Drug Plan

In accordance with N.J.S.A. 18A:16-21 and 40A:10-25, you must file a copy of your new contract with the Health Benefits Bureau. Please submit a copy of the new contract with this completed resolution.

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

Corporate Name of Employer _____ *Phone Number*

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

Print Name _____ *Official Title* _____ *Email Address*

Signature _____ *Date* / /

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