



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 all participation under the SHBP and SEHBP (including prescription drug plan and/or dental plan coverage).

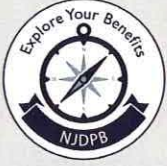
BE IT RESOLVED:

1. The Delaware River Basin Commission 800600
Corporate Name of Employer SHBP/SEHBP Employer Location Number
 hereby resolves to terminate its participation in the Program (Medical Plan, Prescription Drug Plan, and/or Dental Plan coverage) thereby canceling coverage provided by the SHBP and/or SEHBP (N.J.S.A. 52:14-17.25 et seq.) for all its active and retired employees.
2. We shall notify all active employees of the date of their termination of coverage under the Program.
3. We understand that the New Jersey Division of Pensions & Benefits (NJDPB) will notify retired employees of the cancellation of their coverage.
4. We understand that all COBRA participants will be notified by the NJDPB and advised to contact our office concerning a possible alternative health, prescription drug, and dental insurance plan.
5. 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 or School Employees' Health Benefits Commission.

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

<u>Delaware River Basin Commission</u>			<u>609-883-9500</u>
<small>Corporate Name of Employer</small>			<small>Phone Number</small>
<u>25 Cosey Road</u>	<u>West Trenton</u>	<u>NJ</u>	<u>08626</u>
<small>Street Address</small>	<small>City</small>	<small>State</small>	<small>Zip Code</small>
<u>Elba Deck</u>	<u>Director of Finance & Administration</u>	<u>elba.deck@drbc.gov</u>	
<small>Print Name</small>	<small>Official Title</small>	<small>Email Address</small>	
<u></u>			<u>8 / 26 / 2025</u>
<small>Signature</small>			<small>Date</small>
<u>26</u>	<u>23-1605892</u>		
<small>Number of Employees</small>	<small>Employer's State Employer Identification Number (EIN)</small>		

Please complete page 2 of this form.



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RESOLUTION

Please complete and comply with the following:

Type of funding method with the new contract:

☐ Conventionally insured _____

☐ Minimum premium _____

☐ Administrative Services Only (ASO) _____

☒ Other (please list) self-insured consortium

☒ New Health Carrier Central NJ Regional Health Insurance Fund

☒ New Prescription Drug Carrier Central NJ Regional Health Insurance Fund

☒ New Dental Plan Carrier Central NJ Regional Health Insurance Fund

☒ Reason for termination from the SHBP/SEHBP _____

Competitive pricing & long term stability for the Delaware River Basin Commission

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 State Health Benefits Commission or School Employees' Health Benefits Commission. Please submit a copy of the new contract with this completed resolution.

Mail Completed Resolution to:

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