FH-0170-0715

STATE OF NEW JERSEY
DEPARTMENT OF THE TREASURY
DIVISION OF PENSIONS AND BENEFITS
STATE HEALTH BENEFITS PROGRAM
SCHOOL EMPLOYEES' HEALTH BENEFITS PROGRAM
PO BOX 299 TRENTON, NEW JERSEY 08625-0299

R E S O L U T I O N

A **RESOLUTION to elect an employer premium delay option** as selected below.

- ☐ One month delay (initial election)
- ☐ Two month delay (initial election)
- ☐ Add additional one month delay for a maximum employer premium delay of two months (for locations that have previously adopted a one month premium delay)

BE IT RESOLVED:

The _____ _____
NAME OF EMPLOYER - COUNTY SHBP/SEHBP #

hereby resolves to exercise its employer premium delay option under the State Health Benefits Program and/or School Employees' Health Benefits Program as selected above, commencing with the

_____ _____ premium.
MONTH YEAR

We understand that, should our group elect to terminate State Health Benefits Program and/or School Employees' Health Benefits Program participation sometime in the future or the Programs cease to exist, any delayed premiums will become due and payable immediately. We understand that this premium delay shall take effect 60 days following receipt of this resolution by the State Health Benefits Commission or School Employees' Health Benefits Commission. Since employee premium contributions are tax deferred, the submission of those contributions cannot be delayed or used for any other purpose other than the payment of healthcare premiums. Therefore, employee premium contributions **must** be remitted timely.

We understand, in accordance with N.J.S.A. 17:9-5.3(b), that full payment of health benefit charges must be received on or before the due date printed on the bill and that interest shall be applied to the total transmittal of health benefit charges from the day following the due date until the day payment is received. Coverage for employees and retirees may be terminated for amounts 90 or more days past due.

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

_____
CORPORATE NAME OF EMPLOYER

on the_____day of_____, 20____.

_____
STREET A D D R E S S

_____
SIGNATURE

_____
CITY STATE ZIP CODE

_____
OFFICIAL TITLE

_____
AREA CODE TELEPHONE NUMBER