State of New Jersey • Division of Pensions & Benefits (NJDPB)
State Health Benefits Program (SHBP) • School Employees' Health Benefits Program (SEHBP)

TRANSMITTAL OF DELETIONS

Please see page 2 for instructions.

1. Employer Number: _____ 2. Employer Name: _____ 3. County: _____ 4. Date: _____

5. Signature of Certifying Officer is required (1st page only): _____ 6. Page _____ of _____

7. Name of Employee to be Deleted Last, First, M.I.	8. Plan Term			9. Deletion Code & Date		10. Social Security Number	11. 10- or 12-Month Employee	12. Date Coverage Terminates Month/Year
	a. Health	b. Rx	c. Dental	a. Code FLS DTR	b. Last Date of Employment			

Total Number of Deletions Submitted: _____

TRANSMITTAL OF DELETIONS

INSTRUCTIONS

This form must be filed before the 5th of the month preceding the month in which coverage is terminated.

1. **Employer Number** — Enter the employer number found on your SHBP/SEHBP report, for example 0350-0.
2. **Employer Name** — Enter the name of the employer completing the form.
3. **County** — Enter the county in which the employer is located.
4. **Date** — Enter the date you are preparing this form (must be completed).
5. **Signature of Certifying Officer** — Sign only the first page of the report. Statute provides that the certifying officer is responsible for submission of this information (must be completed).
6. **Page ___ of ___** — Enter the page number and the total number of pages in the report.
7. **Name of Employee to be Deleted** — Enter the employee's full name (last, first, middle initial). Only names of employees who are enrolled in the SHBP/SEHBP and are to be terminated from coverage should be entered on this form.

   Do not enter new employees who reject/waive coverage. They must complete a *Health Benefits Enrollment and/or Change Form.*
8. **Plan Termination** — Please place an (X) the plan(s) to be terminated — Health and/or Rx and/or Dental.

9a. **Deletion Code** — Enter the appropriate code. If termination immediately follows the end of a family leave, insert (F). For all other cases, enter the following codes: leave of absence (L), sabbatical (S), death (D), termination for resignation, reduction in force, or reduction in hours (T), or for retirement (R).

9b. **Last Date of Employment** — Enter the last day of employment or date of death.

10. **Social Security Number** — Enter the employee's Social Security number.
11. **10- or 12-Month Employee** — Enter "10" if the employee is reported as working 10 months a year. Enter "12" if the employee is reported as working 12 months a year.

Return completed form to:

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