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

RESOLUTION

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 _____ _____
   Corporate Name of Employer *SHBP/SHEBP 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:

_____ ____/____/_____
Corporate Name of Employer *mm dd yyyy*

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

_____
Area Code *Telephone Number*

_____ _____
Signature *Official Title*

_____ _____
Number of Employees *Employer's State Employer Identification Number (EIN)*

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) _____

  _____
- ☐ New Health Carrier _____
- ☐ New Prescription Drug Carrier _____
- ☐ New Dental Plan Carrier _____
- ☐ Reason for termination from the SHBP/SEHBP _____

  _____

  _____

  _____

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