HB-0688-0522

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 authorize participation for domestic partnership coverage under the SHBP and/or SEHBP in accordance with P.L. 2008, c. 246 (Chapter 246), the domestic partnership act.

BE IT RESOLVED:

1. The _____ _____ ,
   Name of Employer *SHBP/SHEBP Employer Location Number*
   a participating employer in the SHBP and/or SEHBP, hereby elects to participate in the Domestic Partnership coverage provided by the New Jersey State Health Benefits Act (N.J.S.A. 52:14-17.25 et seq.) and to authorize coverage for all the active and retired employees and their domestic partners thereunder in accordance with the statute and regulations adopted by the State Health Benefits Commission (SHBC) and School Employees' Health Benefits Commission (SEHBC).

2. As a participating employer, we will remit to the State Treasury all premiums on account of active and retired employee and dependent coverage and periodic charges in accordance with the requirements of the statute and the rules and regulations duly promulgated thereunder.

3. As a participating employer, we will be responsible for the reporting of active and retired employees' imputed income associated with coverage of domestic partners and will pay all employer federal taxes due on that imputed income.

4. That domestic partnerships must meet the requirements of the Domestic Partnership Act and a *Certificate of Domestic Partnership*, obtained from the State of New Jersey through application to the employee's Local Registrar prior to February 19, 2007 (or a valid certification from another jurisdiction that recognizes same-sex domestic partners, civil unions, or similar same-sex relationships), must be made available along with any other required documentation upon request of the employer and/or the Health Benefits Bureau of the New Jersey Division of Pensions & Benefits (NJDPB).

5. We hereby appoint _____ to act as Certifying Officer in the administration of this program.
   Name/Title

6. This resolution shall take effect immediately and coverage shall be effective as of _____/_____/_____, or as soon thereafter as it may be effectuated pursuant to the statutes and regulations.
   Date

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*

_____ _____/_____/_____
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