



State Health Benefits Program (SHBP)

Local Government Employers

RESOLUTION FOR PARTICIPATION IN RETIRED RX

To be completed by the employing agency's Certifying Officer.

A resolution to authorize participation under the SHBP for retired prescription drug coverage for locations that previously opted out.

BE IT RESOLVED:

1. The _____, *Corporate Name of Employer* _____, *SHBP Employer Location Number* _____, a participating employer in the SHBP, hereby elects to participate in the Retired Prescription Drug Program 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 retirees and their dependents thereunder in accordance with the statute and regulations adopted by the State Health Benefits Commission (SHBC).
2. As a participating employer, we will remit to the State Treasury all charges due on account of retiree and dependent coverage and periodic charges in accordance with the requirements of the statute and the rules and regulations duly promulgated thereunder.
3. We hereby appoint _____, *Name/Title* _____ to act as Certifying Officer in the administration of this program.
4. This resolution shall take effect immediately and coverage shall be effective as of _____ / _____ / _____, *Date* or as soon thereafter as it may be effectuated pursuant to the statutes and regulations.

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

Email Completed Resolution to: HBRetired@treas.nj.gov