



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 terminate participation under the SHBP/SEHBP for prescription drug coverage only.

BE IT RESOLVED:

- 1. The [Name of Employer] [SHBP/SEHBP Employer Location Number] hereby resolves to terminate its participation in the State Employee Prescription Drug Plan...
2. We shall notify all active employees of the date of their termination of coverage under the Program.
3. We understand that all participants in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) will be notified by the New Jersey Division of Pensions & Benefits...
4. We understand that this resolution shall take effect the first of the month following a 60-day period...
5. We understand that this plan must be comparable in design, as determined by the Commission, to the State Employee Prescription Drug Plan.

Please complete and comply with the following:

New Prescription Drug Carrier
Reason for termination of the State Employee Prescription Drug Plan

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 Health Benefits Bureau. Please submit a copy of the new contract with this completed resolution.

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