HB-0721-0923

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 in the SHBP/SEHBP dental plan coverage only.

BE IT RESOLVED

1. The _____ _____
   Name of Employer *SHBP/SHEBP Employer Location Number*
   hereby resolves to terminate its participation in the SHBP/SEHBP Employee Dental Plans thereby canceling dental coverage provided by the New Jersey State Health Benefits Program Act (N.J.S.A. 52:14-17.25 et seq.) for all its active employees and their dependents.
2. We shall notify all active employees of the date of their termination of coverage under the Program.
3. We understand that all COBRA participants will be notified by the New Jersey Division of Pensions & Benefits (NJDPB) and advised to contact our office concerning a possible alternative dental program.
4. 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.

   Please complete and comply with the following:

   New Dental Plan Carrier _____

   Reason for termination of the SHBP/SEHBP Employee Dental Plans _____

   _____

   _____

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. 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* *Email Address*

_____ _____/_____/_____
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