



State Health Benefits Program (SHBP) & School Employees' Health Benefits Program (SEHBP)
RESOLUTION: Authorization to Participate in SHBP/SEHBP

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

A resolution to authorize participation under the SHBP and/or SEHBP.

BE IT RESOLVED:

1. The _____
Corporate Name of Employer SHBP/SHEBP Employer Location Number

hereby elects to participate in the Health Program provided by the New Jersey State Health Benefits Act of the State of New Jersey (N.J.S.A. 52:14-17.26 and N.J.S.A. 52:14-17.46.2) and to authorize coverage for all the employees and their dependents thereunder in accordance with the statute and regulations adopted by the State Health Benefits Commission and/or School Employees' Health Benefits Commission.

2. a. [] We elect to participate in the Employee Prescription Drug Plan defined by N.J.S.A. 52:14-17.25 et seq. and authorize coverage for all employees and their dependents in accordance with the statute and regulations adopted by the State Health Benefits Commission and/or School Employees' Health Benefits Commission.

b. [] We will be maintaining _____ as our Prescription Drug Plan¹.
Name of Plan
This plan is comparable in design to the State Employee Prescription Drug Plan.

c. [] We will not have a stand-alone prescription drug plan and understand that prescription drug coverage will be provided based on the medical plan chosen by the subscriber.

3. a. [] We elect to participate in the Employee Dental Plans defined by N.J.S.A. 52:14-17.25 et seq. and authorize coverage for all employees and their dependents in accordance with the statute and regulations adopted by the State Health Benefits Commission and/or School Employees' Health Benefits Commission.

b. [] We will be maintaining _____ as our dental plan¹.
Name of Plan

c. [] We will not have a dental plan.

4. We elect _____² hours per week (average) as the minimum requirement for full-time status in accordance with N.J.A.C. 17:9-4.6.

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

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

Note: An individual is permitted coverage as an employee, retiree, or dependent. Multiple coverage under the SHBP or SEHBP is prohibited.

¹ If not electing prescription drug coverage and/or dental plan participation through the SHBP or SEHBP, attach copies of the current prescription drug and dental plan contracts.

² May not be less than 25 hours per week for employees, or 35 hours per week for elected or appointed officials.



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7. 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 (can be no less than 75 or 90 days pursuant to the provisions of N.J.S.A. 17:9-1.4).

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

Or Email:
Your Designated NJDPB Health Benefits Group Email Box found on the Resources & Support page in your Benefitsolver Administrator account.