



State Health Benefits Program (SHBP) & School Employees' Health Benefits Program (SEHBP)
RESOLUTION: Change Rx Participation

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

A resolution to authorize a change in participation in the employee prescription drug program.

BE IT RESOLVED:

1. The _____, *Corporate Name of Employer* _____, *SHBP/SEHBP Employer Location Number* _____,
 a participating employer in the SHBP/SEHBP, hereby elects to participate in the Employee 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 employees and their dependents thereunder in accordance with the statute and regulations adopted by the State Health Benefits Commission/School Employees' Health Benefits Commission (SHBC/SEHBC); or
 a participating employer in the SHBP/SEHBP, hereby elects to not have a stand-alone prescription plan and understands that prescription drug coverage will be provided based on the medical plan chosen by the subscriber.
2. 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.
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 _____ / _____ / _____, 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* _____ *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.**