HB-80-184-0525

State Health Benefits Program (SHBP) & School Employees' Health Benefits Program (SEHBP)

RESOLUTION: Terminate Rx Participation

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 thereby canceling prescription drug coverage provided by the SHBP/SEHBP (N.J.S.A. 52:14-17.25 et seq.) for all its active employees; or

   ☐ hereby resolves to terminate its participation in the SHBP/SEHBP prescription drug coverage provided based on the medical plan chosen by the subscriber.

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 and advised to contact our office concerning a possible alternative prescription drug 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 (SHBC) or the School Employees' Health Benefits Commission (SEHBC).
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* *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.