HB-0688-0510

STATE OF NEW JERSEY
DEPARTMENT OF THE TREASURY
DIVISION OF PENSIONS AND BENEFITS
STATE HEALTH BENEFITS PROGRAM
SCHOOL EMPLOYEES' HEALTH BENEFITS PROGRAM
PO BOX 299 TRENTON, NEW JERSEY 08625-0299

R E S O L U T I O N

A RESOLUTION to authorize participation for Domestic Partnership Coverage under the State Health Benefits Program and/or School Employees' Health Benefits Program of the State of New Jersey in accordance with Chapter 246, P.L. 2003, the Domestic Partnership Act.

BE IT RESOLVED:

1. The ______________________________ (NAME OF EMPLOYER) ______________________, (SHBP/SEHBP LOCATION NUMBER)

   a participating employer in the State Health Benefits Program and/or School Employees" health Benefits Program hereby elects to participate in the Domestic Partnership coverage provided by the State Health Benefits Act of the State of New Jersey (N.J.S.A. 52:14-17.25 et seq.) and to authorize coverage for all the active and retired employees and their domestic partners thereunder in accordance with the statute and regulations adopted by the State Health Benefits Commission and School Employees' Health Benefits Commission.

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

3. As a participating employer, we will be responsible for the reporting of active and retired employees' imputed income associated with coverage of domestic partners and will pay all employer federal taxes due on that imputed income.

4. That domestic partnerships must meet the requirements of the Domestic Partnership Act and a *Certificate of Domestic Partnership*, obtained from the State of New Jersey through application to the employee's Local Registrar prior to February 19, 2007 (or a valid certification from another jurisdiction that recognizes same-sex domestic partners, civil unions, or similar same-sex relationships), must be made available along with any other required documentation upon request of the employer and/or the Health Benefits Bureau of the Division of Pensions and Benefits.

5. We hereby appoint ______________________________ (NAME/TITLE) to act as Certifying Officer in the administration of this program.

6. This resolution shall take effect immediately and coverage shall be effective as of ____________ (DATE) or as soon thereafter as it may be effectuated pursuant to statutes and regulations.

I hereby certify that the foregoing is a true and correct copy of a resolution duly adopted by the

____
CORPORATE NAME OF EMPLOYER

on the ______ day of ______________, 20____.

____
STREET ADDRESS

____
SIGNATURE

____
CITY STATE ZIP CODE

____
OFFICIAL TITLE

____
AREA CODE TELEPHONE