



## TRANSMITTAL OF DELETIONS INSTRUCTIONS

1. **Employer Number** — Enter the employer number found on your SHBP/SEHBP report, for example 0350-0.
2. **Employer Name** — Enter the name of the employer completing the form.
3. **County** — Enter the county in which the employer is located.
4. **Date** — Enter the date you are preparing this form (must be completed).
5. **Signature of Certifying Officer** — Sign only the first page of the report. Statute provides that the certifying officer is responsible for submission of this information (must be completed).
6. **Page \_\_\_ of \_\_\_** — Enter the page number and the total number of pages in the report.
7. **Name of Employee to be Deleted** — Enter the employee's full name (last, first, middle initial). Only names of employees who are enrolled in the SHBP/SEHBP and are to be terminated from coverage should be entered on this form.  
  
Do not enter new employees who reject/waive coverage. They must complete a *Health Benefits Enrollment and/or Change Form*.
8. **Plan Termination** — Please place an (X) the plan(s) to be terminated — Health and/or Rx and/or Dental.
- 9a. **Deletion Code** — Enter the appropriate code. If termination immediately follows the end of a family leave, insert (F). For all other cases, enter the following codes: leave of absence (L), sabbatical (S), death (D), termination for resignation, reduction in force, or reduction in hours (T), or for retirement (R).
- 9b. **Last Date of Employment** — Enter the last day of employment or date of death.
10. **Social Security Number** — Enter the employee's Social Security number.
11. **10- or 12-Month Employee** — Enter "10" if the employee is reported as working 10 months a year. Enter "12" if the employee is reported as working 12 months a year.

**Return completed form to:**  
**New Jersey Division of Pensions & Benefits**  
**Health Benefits Bureau**  
**P.O. Box 299**  
**Trenton, NJ 08625-0299**