



RESOLUTION

A Resolution to Authorize a Change in the Percentage of Dependent Coverage to be Paid by the Employer.

BE IT RESOLVED:

1. The _____, *Corporate Name of Employer* _____, *SHBP/SEHBP Employer Location Number*

a participating employer in the SHBP/SEHBP, hereby elects to authorize a change in the percent of premiums paid for employee and/or dependent coverage by the employer.

a.) We authorize _____ percent of employee coverage to be paid.*

b.) We authorize _____ percent of dependent coverage to be paid.*

**If a different percent of premiums applies to separate bargaining groups or employees with no majority representative, indicate the name of the group and the percent of premiums paid on a separate sheet.*

- 2. In accordance with N.J.S.A. 52:14-17.38, we shall remit to the State Treasury all contributions to premiums on account of employee and dependent coverage and periodic changes.
- 3. We shall resolicit all affected eligible employees for completion of *Health Benefit Enrollment and/or Change Forms* to be submitted to the Health Benefits Bureau of the New Jersey Division of Pensions & Benefits within the prescribed time limit.
- 4. This resolution shall take effect immediately and the change in percent of employee and/or dependent premium paid by the employer shall be effective as of / / or as soon thereafter as it may be effectuated pursuant to the statutes and regulations.
mm / dd / yyyy

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

Corporate Name of Employer / /
mm / dd / yyyy

Street Address *City* *State* *Zip Code*

Area Code *Telephone Number*

Signature *Official Title*

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**