HB-0169-0712p

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

RESOLUTION

A RESOLUTION to terminate all participation under the State Health Benefits Program and School Employees' Health Benefits Program (including Prescription Drug Plan and/or Dental Plan coverage).

BE IT RESOLVED:

1. The Township of Mount Olive
   CORPORATE NAME OF EMPLOYER — COUNTY
   hereby resolves to terminate its participation in the program (Medical Plan, Prescription Drug Plan, and/or Dental Plan coverage) thereby canceling coverage provided by the State Health Benefits Program and/or School Employees' Health Benefits Program (N.J.S.A. 52:14-17.25 et seq.) for all of its active and retired employees.
2. We shall notify all active employees of the date of their termination of coverage under the program.
3. We understand that the Division of Pensions and Benefits will notify retired employees of the cancellation of their coverage.
4. We understand that all COBRA participants will be notified by the Division of Pensions and Benefits and advised to contact our office concerning a possible alternative health, prescription drug, and dental insurance plan.
5. 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 or School Employees' Health Benefits Commission.

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

Township of Mount Olive
CORPORATE NAME OF EMPLOYER

on the _____ day of _____, 20____.

_____
SIGNATURE

_____
OFFICIAL TITLE

204 Flanders-Drakestown Rd
STREET ADDRESS

Budd Lake NJ 07828
CITY STATE ZIP CODE

(973) 691-0900
AREA CODE TELEPHONE NUMBER

Please complete the reverse side of this form

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PLEASE COMPLETE AND COMPLY WITH THE FOLLOWING:

A. Employer New Jersey State Health Benefits Program or School Employees' Health Benefits Program Identification Number 0172-00

B. Type of funding method with the new contract:

1. Conventionally insured _____
2. Minimum premium _____
3. Administrative Services Only (ASO) _____
4. Other (please list) Health Insurance Fund

C. New Health Carrier Aetna

D. New Prescription Drug Carrier Express Scripts

E. New Dental Plan Carrier N/A

F. Reason for termination from the State Health Benefits Program/School Employees' Health Benefits Program

Cost Savings

G. 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 State Health Benefits Commission or School Employees' Health Benefits Commision. Please submit a copy of the new contract with this completed resolution.