HB-0077-0807

STATE OF NEW JERSEY
DEPARTMENT OF THE TREASURY
DIVISION OF PENSIONS AND BENEFITS
NEW JERSEY STATE HEALTH BENEFITS PROGRAM
PO Box 299 Trenton, New Jersey 08625-0299

RESOLUTION

A RESOLUTION to authorize participation in the New Jersey State Health Benefits Program Act of the State of New Jersey.

BE IT RESOLVED:

1. The Township of Mount Olive (Corporate Name of Employer) 226-002-117/000 (State Social Security I.D. Number) hereby elects to participate in the Health Program provided by the New Jersey 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 employees and their dependents thereunder in accordance with the statute and regulations adopted by the State Health Benefits Commission.

2. A. ☒ We elect to participate in the SHBP Employee Prescription Drug Plan defined by N.J.S.A. 52:14-17.25 et seq. and authorize coverage for all employees and their dependents in accordance with the statute and regulations adopted by the State Health Benefits Commission.

   B. ☐ We will be maintaining ____________________ (Name of Plan) as our prescription drug plan.[1]

   C. ☒ We will not have a stand-alone prescription drug plan and understand that prescription drug coverage will be provided by the Health Plan.

3. A. ☐ We elect to participate in the SHBP Employee Dental Plans defined by N.J.S.A. 52:14-17.25 et seq. and authorize coverage for all employees and their dependents in accordance with the statute and regulations adopted by the State Health Benefits Commission.

   B. ☒ We will be maintaining Delta Dental (Name of Plan) as our dental plan.[1]

   C. ☐ We will not have a dental plan.

4. We elect 25[2] hours per week (average) as the minimum requirement for full time status in accordance with N.J.A.C. 17:9-4.6.

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

6. We hereby appoint William H. Sohl Business Administrator (Name/Title) to act as Certifying Officer in the administration of this program.

7. 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 the statutes and regulations.

[1] *If not electing prescription drug coverage and/or dental plan participation through the SHBP, attach copies of current prescription drug and dental plan contracts.*

[2] *May not be less than 20 hours.*

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

Towship Council of the Township of Mount Olive
Corporate Name of Employer

on the _____ day of ____________________, 20____.

____
Signature

Township Clerk
Official Title

180 Employees
Number of Employees

204 Flanders-Drakestown Road
Street Address

Budd Lake | New Jersey | 07828
City | State | ZIP Code

(973) 691-0900
Area Code Telephone

226-002-117/000
Employer's State Social Security Identification Number