FIRE DISTRICT # 6
TOWNSHIP OF GLOUCESTER
CAMDEN COUNTY, NEW JERSEY
2025

R- 36-25

RESOLUTION OF THE BOARD OF FIRE COMMISSIONERS
FIRE DISTRICT #6, TOWNSHIP OF GLOUCESTER, CAMDEN COUNTY
NEW JERSEY APPROVING EMPLOYEE HEALTH CARE BENEFIT WAIVER
REIMBURSEMENT

WHEREAS. The Board of Fire Commissioners did previously approve a waiver of health care benefits for employee Adam Craig, as authorized by N.J.S.A 52:14-17.31 and N.J.S.A. 40A:10-17.1 and

WHEREAS. N.J.S.A 52:14-17.31 and N.J.S.A. 40A:10-17.1 does establish the contracting unit may pay to an employee an amount, in the discretion of the employee, not to exceed 25% of the amount saved or a maximum of $5,000.00 per year which ever is less, and

WHEREAS. The Board has determined employee Adam Craig is entitled to an amount of $ 5,000 for the year 2025.

NOW THEREFORE, it is hereby RESOLVED by the Board of Fire Commissioners, Fire District # 6, Township of Gloucester, Camden County New Jersey;

1. That payment is hereby authorized to be made to Adam Craig, Career Firefighter, in the amount of $ 5,000.00, as a Health Care Benefit Waiver for the year 2025.

DATED:

George L. Brown

George Brown, Chairman

I, Renee Evans, Clerk of the Board of Fire Commissioners, do hereby certify that the foregoing is a true and correct copy of a resolution duly adopted by Fire District # 6 of the Township of Gloucester at a regular meeting of the Board of Fire Commissioners held on November 20th 2025.

Renee Evans
Clerk, Board of Fire Commissioners

ADAM CRAIG	ANNUAL PREMIUM	PERCENT OF PREMIUM	TENTATIVE DEDUCTION	PENSION WAGE	ONE AND A HALF %	ACTUAL DEDUCTION	Savings to the District	25%
Year								
2025	36,272.40	35.00%	12,695.34	**102,215.00**	1,533.23	12,695.34	23,577.06	5,894.27

2025 SHBP RATES

NJ DIRECT 10#050	Member & Spouse	2,549.92
RX Program #201	Member & Spouse	472.78
Monthly Total		**3,022.70**

HA-0109-0519

State Health Benefits Program (SHBP) • School Employees' Health Benefits Program (SEHBP)

ACTIVE LOCAL GOVERNMENT AND LOCAL EDUCATION EMPLOYEE GROUP

EMPLOYEE COVERAGE WAIVER/REINSTATEMENT FORM

PART 1: EMPLOYEE INFORMATION — Last Name: Craig | First: Adam | MI: D.

Gender	Birth Date	Social Security Number	Marital Status*
M	09/12/83	147-84-1372	M

Telephone Number	Personal Email Address
(856) 904-0940	acraig@gtfd6.com

Home Address No. and Street Name: 29 Sturbridge Drive

City	State	Zip
Sicklerville	NJ	08081

EMPLOYMENT STATUS ☑ Full Time ☐ National Guard

DIVISION USE ONLY

Effective Dates — Event Reason:

H ____ ____ ____ ☐

Rx ____ ____ ____

EMPLOYER CERTIFICATION
(See Instructions on reverse)

Employer Name _____

Location # (State Monthly)

☐☐☐☐☐☐☐

10/12 - month employee *(Enter "10 or 12")* ☐☐

MEMBER ACTION

☐ New Enrollment ☐ Existing

Date Employment Began

____/____/____

_____
Signature of Certifying Officer

_____
Telephone # *Date Mailed*

Check one box below.

☑ **Waiver of Coverage**

In accordance with P.L. 2007, c. 92 (Chapter 92) and P.L. 2010, c. 2 (Chapter 2), I have agreed to waive coverage (medical and, if applicable, prescription drug coverage) with the State Health Benefits Program (SHBP) or School Employees' Health Benefits Program (SEHBP) to which I am entitled because I am covered under other health coverage. I understand that I am not eligible for the waiver incentive if my other coverage is with the SHBP or SEHBP. **Note:** You must submit proof of the other health coverage to your employer along with this form.

In place of health benefit coverage, my employer will pay me the amount shown in Part 2 below. I understand that I may resume SHBP or SEHBP coverage when I am no longer covered by the other health coverage, provided that I notify the Health Benefits Bureau within 60 days of the loss of the other coverage and provide proof of loss of that coverage.

I wish to waive *(check one)* ☐ Medical Coverage ☐ Prescription Coverage ☑ Both

☐ **Reinstatement of Coverage**

I previously waived SHBP or SEHBP coverage because I had other health coverage. As of ____/____/____, I am no longer covered by the other health plan, request reinstatement of health benefits coverage with the SHBP or SEHBP, and have provided proof of loss of the other coverage. I further understand that coverage is permitted as an employee, retiree, or dependent; however, multiple coverage under the SHBP or SEHBP is prohibited. A *Health Benefits Enrollment and/or Change Form* along with proof of loss of other coverage, is required for all reinstatements.

Employee's Signature _____ **Date** 01/01/26

PART 2: To be completed by the employer. Check one box below.

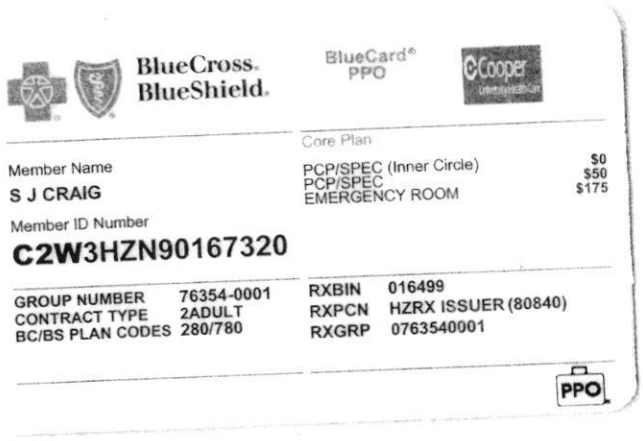
☐ We will pay the above employee $_____ every _____ in place of providing SHBP or SEHBP coverage. We understand that this payment may not be more than 25 percent of the amount saved by the employer because of the waiver or $5,000, whichever is less.

☐ We request reinstatement of this employee's SHBP or SEHBP coverage.

The reinstatement application must be filed within 60 days of the loss of other health coverage. If this timetable is followed, the coverage will be retroactive to the date of loss. If the 60 day time limit has passed, the employee must wait until the next open enrollment period to reenroll.

MAIL COMPLETED APPLICATION TO:

New Jersey Division of Pensions & Benefits
Health Benefits Bureau
P.O. Box 299
Trenton, NJ 08625-0299


BlueCross.
BlueShield.
BlueCard®
PPO
Cooper
Member Name
S J CRAIG
Member ID Number
C2W3HZN90167320
Core Plan
PCP/SPEC (Inner Circle) $0
PCP/SPEC $50
EMERGENCY ROOM $175
GROUP NUMBER 76354-0001
CONTRACT TYPE 2ADULT
BC/BS PLAN CODES 280/780
RXBIN 016499
RXPCN HZRX ISSUER (80840)
RXGRP 0763540001
PPO