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

R-37-25

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 Jason Stott, 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 Jason Stott is entitled to an amount of $ 5,000.00 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 Jason Stott, 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

JASON STOTT	ANNUAL PREMIUM	PERCENT OF PREMIUM	TENTATIVE DEDUCTION	PENSION WAGE	ONE AND A HALF %	ACTUAL DEDUCTION	Savings to the District	25%
Year								
2025	50,600.04	28.00%	14,168.01	92,910.00	1,393.65	14,168.01	36,432.03	9,108.01

2025 SHBP RATES

NJ DIRECT 10#050	Family	3,557.14	
RX Program #201	Family	659.53	
Monthly Total		**4,216.67**	Jason

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 | First | MI

Gender	Birth Date	Social Security Number	Marital Status*
	/ /	— —	

Telephone Number: ( )

Personal Email Address

Home Address No. and Street Name

City | State | Zip

EMPLOYMENT STATUS ☐ Full Time ☐ National Guard

Check one box below.

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*

☐ **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** ____/____/____

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

DEPARTMENT OF DEFENSE
MANPOWER DATA CENTER
400 GIGLING ROAD
SEASIDE, CALIFORNIA 93955-6771

ELIG

Nov 19, 2025

Jason R. Stott
400 GRAND AVE
BLACKWOOD, NJ, 08012-4536

Dear Jason R. Stott,

This letter is regarding coverage for TRICARE administered programs such as TRICARE Select, TRICARE Prime, TRICARE For Life, TRICARE Reserve Select, etc. Military health care benefits are provided to active duty, retired and Reserve Service members, as well as authorized family members. This includes Service members who have separated from the military that are entitled to Transitional Assistance.

The Defense Enrollment Eligibility Reporting System reflects that the following individual(s) are currently covered by one of the TRICARE administered programs:

Name	**Effective Date***
Jason R. Stott	10-01-2023
Susan Stott	10-01-2023
Avery M. Stott	10-01-2023
Isabella M. Stott	10-01-2023

This letter may be used as proof of current coverage under a TRICARE administered program.** Any change in the sponsor's status or the family member's status/relationship to the sponsor may impact medical benefits. Loss of coverage may occur for various reasons such as: the sponsor separating from military service or change in active status, divorce, a child marrying or reaching the maximum age for benefits, etc. If changes occur, the information in this letter may no longer be valid.

For questions related to deductibles, specific coverage information, or claims, please contact your TRICARE regional contractor. For information regarding medical care while traveling overseas, please contact the TRICARE overseas contractor. You may find TRICARE's contact information at https://tricare.mil/About/Regions.

For further assistance, visit our Web site at http://milconnect.dmdc.mil or contact the Defense Manpower Data Center Contact Center at (800) 538-9552. Our hours of operation are 5:00 a.m. to 5:00 p.m. (Pacific Time) Monday through Friday.

Sincerely,

Client Services
Defense Manpower Data Center

**The Effective Date above reflects a maximum of six (6) years in the past.*
***If you are entitled to Medicare for any reason regardless of age or place of residence, federal law requires most TRICARE beneficiaries who are entitled to Medicare Part A to have Medicare Part B to remain TRICARE-eligible. For more information about how Medicare affects TRICARE coverage, please visit www.tricare.mil/tfl.*