

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

R-38-25

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

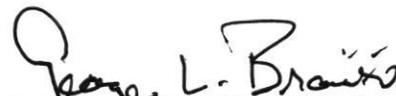
WHEREAS. N.J.S.A 52:14-17.31 and N.J.S.A. 40A:10-17.1 does establish the contracting unit may pay to an employee an amount, in the discretion of the employee, not to exceed 25% of the amount saved or a maximum of \$5,000.00 per year which ever is less, and

WHEREAS. The Board has determined employee Nicholas Woods is entitled to an amount of \$ 2,871.97 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 Nicholas Woods, Career Firefighter, in the amount of \$ 2,871.97, as a Health Care Benefit Waiver for the year 2025.

DATED:


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

Nicholas Woods	ANNUAL PREMIUM	PERCENT OF PREMIUM	TENTATIVE DEDUCTION	PENSION WAGE	ONE AND A HALF %	ACTUAL DEDUCTION	Savings to the District	25%
Year								
2025	13,054.41	12.00%	1,566.53	33,264.00	498.96	1,566.53	11,487.88	2,871.97

Hire Date 3/28/25

2025 SHBP RATES

NJ DIRECT 10#050	Member	1,214.10
RX Program #201	Member	236.39
Monthly Total		1,450.49



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		DIVISION USE ONLY			
Woods				Nicholas		J		Effective Dates		Event Reason:	
Gender	Birth Date		Social Security Number			Marital Status*			H _____ <input type="checkbox"/>		Rx _____ <input type="checkbox"/>
M	10 / 08 / 2000		136 - 08 - 8607			Single			EMPLOYER CERTIFICATION (See Instructions on reverse)		
Telephone Number				Personal Email Address				Employer Name _____			
(609) 670-0002				nickwoods222@gmail.com				Location # (State Monthly)			
Home Address No. and Street Name								10/12 - month employee (Enter "10 or 12") <input type="checkbox"/>			
245 Minton Place								MEMBER ACTION			
City		State		Zip		<input type="checkbox"/> New Enrollment <input type="checkbox"/> Existing		Date Employment Began _____			
Somerdale		New Jersey		08083		Signature of Certifying Officer _____		Telephone # _____ Date Mailed _____			
EMPLOYMENT STATUS				<input checked="" type="checkbox"/> Full Time		<input type="checkbox"/> National Guard					

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 *Nick Woods* Date 1/1/25

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



First Health Network
Complementary



NAP

FREEDOM10
SHBP

Choice POS II

GRP: 237165-012-00001

ID W2141 72940

- 01 HARRY D WOODS
PCP: NO ELECTION REQUIRED
- 02 JENNIFER WOODS
PCP: NO ELECTION REQUIRED
- 03 MATTHEW WOODS
PCP: NO ELECTION REQUIRED
- 04 NICHOLAS WOODS
PCP: NO ELECTION REQUIRED

SELF INSURED

PCP	\$ 10
SPC	\$ 10
HOSP	NO COPAY
ER	\$ 75
UC	\$ 10.00
DEDUCTIBLE MAY APPLY	

PAYER NUMBER 60054 0734

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