Horizon

Horizon Blue Cross Blue Shield of New Jersey

NEW JERSEY SMALL EMPLOYER CERTIFICATION

Legal Name and Address of Company: _____
Name

_____
Street City State ZIP

Group Policy Number or Group Number: _____
(if a current customer)

Group Health Benefits Policy Participation

Please indicate below the number of employees by work location/State. All employees must be included, regardless of whether or not they currently have medical coverage and through whom that coverage is provided.

	Number of Employees				
Work Location (list by State)	Full-time	Part-time	Retired	COBRA or State Continuees	Other

(For Existing Small Employer Groups in the State of New Jersey OR New Applicants)

An Eligible Employee is one who works on a full-time basis with a normal work week of 25 or more hours for compensation. An employee who works less than 25 hours per week on a temporary or substitute basis, or an employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement is not an eligible employee.

Total # Eligible Employees _____

Total # Eligible Employees applying/enrolling for health benefits coverage _____

Total # Eligible Employees waiving health benefits coverage under the policy with coverage under their spouse's coverage, other than individual coverage, Medicare, Medicaid, or NJ FamilyCare or any other group Health Benefits Plan through a different employer _____

Total # Eligible Employees waiving health benefits coverage under the policy with coverage under a Health Benefits Plan issued by another carrier and offered by the small employer _____

Please separately list the name(s) of the other carrier(s) and the number of employees covered under each:

_____ _____

_____ _____

Total # Eligible employees waiving health benefits coverage under the policy without coverage under a spouse's coverage, other than individual coverage; Medicare, Medicaid, or NJ FamilyCare or any other Health Benefits Plan _____

Total # Employees in an ineligible class or classes _____

Is your firm subject to Working Aged Provisions of federal law (TEFRA/DEFRA)? ☐ Yes ☐ No
(You *may* be subject to the law if you employed 20 or more employees for 20 weeks in the current or prior calendar year)

Is your firm subject to the requirements of the federal COBRA law? ☐ Yes ☐ No
(You *may* be subject to the law if you employed 20 or more employees during 50% or more of the working days during the previous calendar year.)

CERTIFICATION AS A SMALL EMPLOYER IN THE STATE OF NEW JERSEY
IN ACCORDANCE WITH NEW JERSEY STATUTE, CHAPTER 27A OF TITLE 17B

For a policy of Group Health Benefits Insurance

(Please sign and date appropriate section indicating whether or not you meet the definition of a small employer)

"Small Employer" means, in connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership or political subdivision that is actively engaged in business that:

- Employed an average of at least two, but not more than 50, eligible Employees on business days during the preceding Calendar Year and
- Employs at least two Employees on the first day of the Plan Year, and
- The majority of the Employees are employed in New Jersey.

All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an employer that was not in existence during the preceding Calendar Year, the determination of whether the employer is a small or large employer shall be based on the average number of Employees that it is expected that the employer will employ on business days in the current Calendar Year.

☐ **I certify that I qualify as a Small Employer in the State of New Jersey.**

AND

☐ **I certify that the information provided to Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) and Horizon Healthcare of New Jersey, Inc., is true and complete.** I understand that if the above information is not complete or is not provided to Horizon BCBSNJ and Horizon Healthcare of New Jersey, Inc., in a timely manner, then health benefits coverage does not have to be offered or continued. I further understand that incomplete or untrue information may void health benefits coverage.

I understand that I and my employees may be subject to fines if an employee who is a resident of New Jersey and is eligible for coverage under this group health benefits plan is enrolled in an individual health benefits plan issued on or after August 1, 1993.

_____

Signature of Officer, Partner or Owner *Title* Date

_____

Print Name of Officer, Partner or Proprietor

_____

Signature of Witness Date

☐ **I certify that I am NOT a Small Employer in the State of New Jersey, as defined above.**

_____

Signature of Officer, Partner or Proprietor *Title* Date

_____

Print Name of Officer, Partner or Proprietor

_____

Signature of Witness Date

Any person who includes any false or misleading information on an application or enrollment form or certification for a health benefits plan is subject to criminal and civil penalties.

COMPLETE THIS SECTION ONLY IF YOU HAVE CERTIFIED THAT YOU ARE A SMALL EMPLOYER IN THE STATE OF NEW JERSEY.

***EMPLOYEE CENSUS INFORMATION**

Please include the following persons in the following list:

a. employees, owners, partners, officers and independent contractors who are actively working for the employer on a regular basis, and are paid by the employer on a regular basis, whether or not they are eligible to be covered under the policy.

b. employees, owners, partners, officers and independent contractors who are not working, but who are currently covered under the employer's health benefits plan for reasons such as continuation of coverage or total disability.

Please use the following letters to indicate Status:

F: Full-time employee who works 25 or more hours per week
P: Part-time employee who works less than 25 hours per week
T: Temporary Employee
I: Independent Contractor
D: Totally Disabled Employee
C: Continuee under state or federal law
U: Employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement.

Name	Job Title	Date of Employment	Hours Worked Per Week	Status	Work Location (State)	Gender	Date of Birth
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2.							
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*If additional space is needed, attach a separate sheet.