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NEW JERSEY SMALL EMPLOYER CERTIFICATION

Company Name ____ Address of Company ____ ____ ____	Customer ID or Group Number (if a current customer) __________________________

(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:

Carrier Name(s): ____ # of Employee(s): _________

*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 AmeriHealth is true and complete**. I understand that if the above information is not complete or is not provided to AmeriHealth 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.

Group Health Benefits Policy Participation

COMPLETE THE FOLLOWING 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

C: Continuee under state or federal law

D: Totally Disabled employee

T: Temporary employee

I: Independent Contractor

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
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							

*If additional space is needed, attach a separate sheet.

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.

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