

## NEW JERSEY SMALL EMPLOYER CERTIFICATION

For a policy of Group Health Benefits Insurance

EMPLOYER NAME: \_\_\_\_\_ GROUP POLICY#: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
Street City State Zip

### 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, 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
- I: Independent Contractor
- P: Part-time employees who work less than 25 hours per week
- D: Total Disabled employee
- T: Temporary 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)
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						

If additional space is needed, attached a separate sheet.

**CERTIFICATION AS A SMALL EMPLOYER IN THE STATE OF NEW JERSEY IN ACCORDANCE WITH NEW JERSEY CH. 162**

Group Health Benefits Policy Participation (All Questions Must Be Answered)

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 # of Eligible Employees	
Total # of Eligible Employees applying/enrolling for health benefits coverage.	
Total # of Eligible Employees waiving health benefits coverage under this policy with coverage under a spouse's coverage, other than individual coverage or any other Health Benefits Plan offered by the employer.	
Total # of Eligible Employees waiving health benefits coverage under this policy without coverage under a spouse's coverage, other than individual coverage or any other Health Benefits Plan offered by the employer.	
Total # of Eligible Employees in an ineligible class or classes.	

**CERTIFICATION:** (Please sign and date appropriate section including 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.**

**I certify that the information provided to AmeriHealth HMO, Inc. and AmeriHealth Insurance Company of New Jersey is true and complete. I understand that if the above information is not complete or is not provided to AmeriHealth HMO, Inc. and AmeriHealth Insurance Company of New Jersey 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.**

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

Signature of Officer, Partner or Owner	Title	Date
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Print Name of Officer, Partner or Owner

Signature of Witness

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

Signature of Officer, Partner or Owner	Title	Date
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Print Name of Officer, Partner or Owner

Signature of Witness	Date
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