



Northeast Regional Office
 P.O. Box 26050
 Lehigh Valley, PA 18002-6050

**NEW JERSEY SMALL EMPLOYER CERTIFICATION
 For a Policy of Group Health Benefits Insurance**

Employer Name

Group Policy No.

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

If additional space is needed, attach 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 pay. 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; or any other Health Benefits Plan offered by the employer _____
- Total # Eligible Employees waiving health benefits coverage under the policy **without** coverage under their spouse's coverage, other than individual coverage; or any other Health Benefits Plan offered by the employer _____
- Total # Employees in an ineligible class or classes _____

CERTIFICATION

(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 fifty eligible employees on business days during the preceding Calendar Year and who 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 Guardian/Health Net of New Jersey, Inc. is true and complete. I understand that if the above information is not complete or is not provided to Guardian/Health Net 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 are 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 for a health benefits plan is subject to criminal and civil penalties.

Signature of Officer, Partner, or Owner Title Date

Print Name of Officer, Partner, or Owner

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 Owner Title Date

Print Name of Officer, Partner, or Owner

Signature of Witness Date