



CERTIFICATION

WellChoice Insurance of New Jersey, Inc.

WellChoice HMO of New Jersey

Effective Date ____/____/____

Renewal Date ____/____/____

For a policy of Group Health Benefits Insurance

Company Name _____

Group Policy No. _____

Address _____

Street _____

City _____

State _____

Zip _____

County _____

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

LIST ALL EMPLOYEES

Name	Job Title	Date of Employment	Hours Worked Per week	*Status (Indicate letter from above)	Work Location	Internal Use
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						

If additional space is needed, attach a separate sheet.

10 TELEPORT DRIVE, STATEN ISLAND, NEW YORK 10311

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). 75% Total Participation Required.

An Eligible Employee is one who works on a full-time basis with a normal work week of 25 hours 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 Number of Eligible Employees _____
- Total Number of Eligible Employees applying for health benefits coverage _____
- Total Number of Eligible Employees waiving health benefits coverage under this policy with coverage elsewhere _____
- Total Number of Eligible Employees waiving health benefits coverage under this policy without coverage elsewhere _____
- Total Number of Non Eligible Employees (example - Union) _____
- Total Number of Part time Employees _____
- Total Number of Employees in waiting periods _____
- Total Number of Employees working out of state _____

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 activity 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 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 WellChoice HMO of New Jersey, and/or WellChoice Insurance of New Jersey, Inc. is true and complete. I understand that if the above information is not complete or is not provided to WellChoice, Inc., and/or WellChoice Insurance 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 plans issued on or after August 1, 1993.

Any person who knowingly files a statement of claim, application for insurance, enrollment form, or certification containing any false or misleading information, may be 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