



Health Net

EMPLOYER CERTIFICATION

Legal Name and Address of Company	Group Policy Number or Group Number (if a current customer)
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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.

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

(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, or any other Health Benefits Plan offered by the employer _____

Total # Eligible employees waiving health benefits coverage under the policy without coverage under a 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 _____

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.)

NJ36647 (4/07) 6013207

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