[Carrier name/logo]

NEW JERSEY EMPLOYER CERTIFICATION
[FOR USE WITH SMALL BUSINESS HEALTH OPTIONS PROGRAM (SHOP)]

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

For purposes of certification as a New Jersey Small Employer, an Employer is considered to be a Small Employer if the Employer satisfies the definition set forth below.

Employee and Small Employer Definitions

The definition of Small Employer counts employees as defined below.

Employee means an employee of the Policyholder. An individual and his or her legal spouse when the business is owned by the individual or by the individual and his or her legal spouse, partners in a partnership, sole proprietors, a 2-percent S corporation shareholder and independent contractors are **not** employees of the Policyholder.

Small Employer means in connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding Calendar Year and who employs at least 1 employee on the first day of the Plan Year.

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 which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

The following calculation must be used to determine if an employer employs at least 1 but not more than 50 employees. For purposes of this calculation:
a) Employees working 30 or more hours per week are full-time employees and each full-time employee counts as 1;
b) Employees working fewer than 30 hours per week are part-time and counted as the sum of the hours each part-time employee works per week multiplied by 4 and the product divided by 120 and rounded down to the nearest whole number.

Add the number of full-time employees to the number that results from the part-time employee calculation. If the sum is at least 1 but not more than 50 the employer employs at least 1 but not more than 50 employees.

Please note: Small Employer includes an employer that employs more than 50 full-time employees if the employer's workforce exceeds 50 full-time employees for no more than 120 days during the calendar year and the Employees in excess of 50 who were employed during such 120-day or fewer period were seasonal workers.

Full-Time Employee Definition

The definition of Full-time Employee is used to determine eligibility for coverage under a small employer plan. Full-time employees are counted when determining participation for a small employer.

Full-Time Employee means an employee who works a normal work week of [25] [30] or more hours. Work must be at the Policyholder's regular place of business or at another place to which an employee must travel to perform his or her regular duties for his or her full and normal work hours. *Note to carriers: Use 25 hours for non-SHOP and 30 hours for SHOP.*

[Please note that the above definition of Small Employer above considers full-time to be 30 hours per week and that definition of full-time is used solely for determining whether an employer is a Small Employer. For purposes of determining which employees are eligible for insurance under a Small Employer plan and whether the Small Employer meets the participation requirement, full-time is defined as 25 hours per week.] *Note to carriers: Omit this paragraph for SHOP.*

Please indicate below the number of employees by work location/State. Refer to the definition of "employee" on page 1. 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 or Former Employees				
	Full-time	Part-time		COBRA or State Continuees	Other

The following information will be used to calculate the **participation** rate. Refer to the definition of "full-time employee" on page 1 that counts employees working 25 or more hours per week.

Total # *Full time employees* _____

Total # Full-time employees applying/enrolling for health benefits coverage _____

Total # Full-time employees waiving health benefits coverage under the policy with coverage under their spouse's or parent's group coverage, Medicare, Medicaid, or NJ FamilyCare or Tricare or any other group Health Benefits Plan **through a different employer** [or coverage under an individual plan] *Note to Carriers: include individual plan for SHOP*. _____

Total # Full-time 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:

_____ _____

_____ _____

Total # Full-time employees waiving health benefits coverage under the policy without coverage under a spouse's or parent's group coverage; Medicare, Medicaid, or NJ FamilyCare or Tricare or any other Health Benefits Plan [or an individual plan] _____

Note to Carriers: Include individual plan for SHOP.

Total # Employees in an ineligible class or classes _____

The following information will be used to determine how certain federal laws apply to the Small Employer.

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)

[If yes, provide the number of full-time and part-time employees you employed for at least 20 or more weeks in the current or prior calendar year. _____

For purposes of this question "employee" **includes**: full-time employees, part-time employees, seasonal employees, temporary employees, employees who are union members, owners, partners, officers and **excludes** self-employed persons, independent contractors (1099), directors]

Note to carriers: The above bracketed information may be included at the option of the carrier.

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.)

[If yes, provide the number of full-time and part-time employees you employed during 50% or more of the working days during the previous calendar year. _____

For purposes of this question "employee" **includes**: full-time employees, part-time employees, seasonal employees, temporary employees, employees who are union members, owners, partners, officers and **excludes** self-employed persons, independent contractors (1099), directors

Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours the part-time employee worked divided by the hours an employee must work to be considered full-time.]

Note to carriers: The above bracketed information may be included at the option of the carrier.

What is the **average** number of employees you employed during the entire **previous calendar year** regardless of whether they were eligible or enrolled for group coverage? _____

(When answering this question please count any employee for whom your company issues a W-2 and include full-time, part-time and seasonal workers.)

CERTIFICATION AS A SMALL EMPLOYER IN THE STATE OF NEW JERSEY

For a Group Health Benefits Plan

Please sign and date appropriate section indicating whether or not you meet the definition of a small employer.

❑ I certify that I qualify as a Small Employer in the State of New Jersey

AND

❑ I certify that the information provided to [Carrier] is true and complete. I understand that if the above information is not complete or is not provided to [Carrier] 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 certify that I have obtained and maintain a stand-alone pediatric dental plan for all employees and dependents enrolling for health benefits coverage.] *(Carriers should omit this statement if the pediatric dental benefit is included in the small employer policy. Also omit this statement for SHOP.)*

_____ _____

Signature of Officer, Partner or Owner Title

_____ _____

Print Name of Officer, Partner or Proprietor Date

_____ _____

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

_____ _____

Print Name of Officer, Partner or Proprietor Date

_____ _____

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.

Complete this section if you have certified that the Employer is a Small Employer

* CENSUS INFORMATION

Please include the following persons in the following list:

a employees, owners, partners, and officers 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 and officers 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:

O: Owner, partner or officer
F: Full-time employee who works [25] [30] or more hours per week Note to carriers: use 25 for non-SHOP and 30 for SHOP.
P: Part-time employee who works less than [25] [30] hours per week Note to carriers: use 25 for non-SHOP and 30 for SHOP.
[T: Temporary employee] *Note to carriers: Include if appropriate.*
S: Seasonal employee (employee works fewer than [ ] [weeks] [days] per year) *Note to carriers: Insert applicable definition*.
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)		Date of Birth
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								

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

[Total Average Number of Employees

January 1 through December 31 – What is the average number of employees you employed including any affiliated companies* during the prior calendar year. An employee is any person to whom you issue a W-2. This includes full-time, part-time, and seasonal workers who may or may not have been eligible for your medical plan or covered by Carrier. To calculate average number of employees, determine the average number of employees for each month, add each month's number to get an annual total, and then divide by 12. Round to the nearest whole number.
*If the business is aggregated with one or more other businesses and treated as a single employer under subsection (b) controlled group of corporations, (c) partnerships, proprietorships, etc., under common control, (m) employees of an affiliated service group, or (o) other regulations of section 414 of the Internal Revenue Code, then please provide the combined total number of employees for all businesses that are included in the "single employer group" under the Internal Revenue Code.

Month:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Average divided by 12
FT EE														~~~~~~~~~~
PT EE														~~~~~~~~~~
Seasonal														~~~~~~~~~~
Total														

] *Note to carriers: Omit this section if you do not need the Total Average Number of Employees information.*