

**THE NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM
20xx CERTIFICATION OF NON-MEMBER STATUS**

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| Carrier Name: | |
| NAIC #: | |
| Mailing Address: | |
| | |

I, (print or type name) _____, a duly authorized officer of the above named entity, hereby certify that this entity:

CHECK ONE OPTION:

| | |
|--------------------------|--|
| <input type="checkbox"/> | Is not a "Carrier" authorized to issue "Health Benefit Plans" in New Jersey, as those terms are defined at N.J.A.C. 11:21-1.2 and N.J.S.A. 17B:27A-17; OR |
| <input type="checkbox"/> | Is a carrier that is not a "Member" of the New Jersey Small Employer Health Benefits Program because it had no "Health Benefits Plan" in force in 20xx covering a New Jersey "Small Employer," as those terms are defined at N.J.A.C. 11:21-1.2 and N.J.S.A. 17B:27A-17. |

The accident and health premiums reported to the New Jersey Department of Banking and Insurance by this carrier for 20xx were entirely attributable to the following types of coverage, all of which are not included in, or are expressly excluded from, the definition of "health benefits plan" in the rule cited above. **If you are not a "Member" you must, in the spaces below, list the types of coverages that make up the carrier's reported A&H premium.**

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| 1. | 4. |
| 2. | 5. |
| 3. | 6. |

Please note: Carriers that cover New Jersey small employers through associations, trusts, or multiple employer arrangements are Members of the Program subject to assessment. If you have questions about this form, call (609) 633-1882, ext. 50302.

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| Printed Name: | |
| Title: | |
| Signature: | Date: |
| E-mail Address: | |
| Phone: | Fax: |