

AmeriHealth Insurance Company of New Jersey  
 AmeriHealth HMO, Inc.  
 259 Prospect Plains Road, Building M  
 Cranbury, NJ 08512  
 Tel 215-640-7573  
 Fax 215-238-7940  
 Email: NJSEH-Cert@amerihealth.com  
 www.amerihealth.com



### New Jersey Small Employer Certification

Customer Name: _____  Address of Company: _____ _____ _____	Customer ID or Group Number (if a current customer)  _____
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**(For Existing Small Employer Groups in the State of New Jersey OR New Applicants)**

The following will be used to determine Small Employer eligibility. Please refer to the definition of "full-time employee" on the next page that counts employees working 25 or more hours/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 coverage, other than individual coverage, Medicare, Medicaid, or NJ FamilyCare or Tricare or any other group Health Benefits Plan through a different employer* \_\_\_\_\_
- \*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:  
 Carrier Name(s): \_\_\_\_\_ # of Employee(s): \_\_\_\_\_
- \*Total # Full-time employees *waiving health benefits coverage under the policy without coverage under a spouse's coverage, other than individual coverage; Medicare, Medicaid, or NJ FamilyCare or Tricare or any other Health Benefits Plan* \_\_\_\_\_
- \*Total # Time employees *waiving health benefits coverage under the policy with coverage through an individual health insurance policy offered by another carrier* \_\_\_\_\_
- \*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.)
- \*What is the **average** number of employees you employed during the entire **previous calendar year** regardless of whether they were eligible for 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.)

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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 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.

**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.**

*Please note: Eligible employees and any dependents to be covered must live, work or reside in the service area of the Group Health Plan.*

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**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 AmeriHealth is true and complete.** I understand that if the above information is not complete or is not provided to AmeriHealth 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 (if applicable).

Signature of Officer, Partner or Owner	Title	Date
Print Name of Officer, Partner or Proprietor		
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 Proprietor	Title	Date
Print Name of Officer, Partner or Proprietor		
Signature of Witness	Date	

**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														
<b>Total</b>														

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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.**

Group Health Benefits Policy Participation

**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:

- |  |                                     |
|--|-------------------------------------|
| <b>O:</b> Owner, Partner or officer  | <b>S:</b> Seasonal Employee         |
| <b>F:</b> Full-time employee who works 25 or more hours per week   | <b>D:</b> Totally Disabled employee |
| <b>P:</b> Part-time employee who works less than 25 hours per week   | <b>T:</b> Temporary employee        |
| <b>C:</b> Continuee under state or federal law   | <b>I:</b> Independent Contractor    |
| <b>U:</b> Employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement. |                                     |

***If you have listed less than 5 (five) enrolled employees, please include tax documents that show proof of ownership and/or employment for all eligible employees. Acceptable documents include:***

- ***New Jersey WR-30 – Employer Report of Wages Paid***
- ***W-2 (if recent)***
- ***W-4 (if needed to verify recent new hire)***
- ***Payroll documents showing taxes taken out***
- ***Schedule C, Schedule K-1 or Schedule F (for owners only)***

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Name	Job Title	Date of Hire	Hours worked per week	Job Status	Work Location (State)	Residence Location (State)	Gender	Date of Birth
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								

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

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.					
Work Location (list by State)	Number of Employees				
	Full-time	Part-time	Retired	COBRA or State Continues	Other