

**Please return this Certification Statement within ten (10) days of receipt.
Thank you in advance for your cooperation.**

CERTIFICATION STATEMENT

Group Name:	Renewal Date:
Group Address:	Telephone: _____
Group Number(s):	E-mail address _____

Section A

Connecticut General Statute (C.G.S.) 38a-564 requires health insurance carriers and health care centers to determine if a firm is a small employer as defined by C.G.S. 38a-564. Anthem Blue Cross and Blue Shield of Connecticut is responsible for updating and documenting this information each year. If you have any questions, please call Randy Quinn at (203) 985-7630 or fax (203) 985-7366.

A “Small Employer” is a person, firm, corporation, partnership, or association actively engaged in business for at least three consecutive months who, for at least one-half of its working days during the last twelve months, employed fifty (50) or fewer eligible employees, the majority of whom were employed in the State of Connecticut. An “eligible employee” means an employee who works on a full-time basis, with a normal work week of thirty or more hours.

Please check “Yes” or “No” for each statement indicated below:

- | | Yes | No | |
|----|-----|-----|---|
| 1. | () | () | - My company meets the definition of a “Small Employer” as defined above. |
| 2. | () | () | - Other than part-time employees, are all of your employees actively at work and working 30 or more hours per week over the last 12-month period? |
| 3. | () | () | - Are there any employees that work less than 30 hours per week due to a total disability (TD) or are on a long term leave of absence (LOA) over 16 weeks? If yes, please identify below: |

	Employee’s Name	Social Security Number	Date of Disability and Explanation
1.	_____		
2.	_____		
3.	_____		

Section B – Eligibility

PLEASE NOTE: **Questions 2a through 2e must add up to question 1b.** If there is a discrepancy, please explain why.

1a.	Total number of full time and part time employees in company Including owners:	<input type="text"/>
b.	Total number of full time employees working a minimum of 30 hours per week including owners:	<input type="text"/>
2a.	Total number of full time employees covered under a Taft Hartley Trust Agreement (UNION):	<input type="text"/>
b.	Total number of full time employees not covered due to enrollment in spouse's employer health plan:	<input type="text"/>
c.	Total number of full time employees covered by Anthem BC/BS: (Includes all health plans)	<input type="text"/>
d.	Total number of full time employees covered with other HMO or insurance company:	<input type="text"/>

(Please name other company)		
e.	Number of full time employees who have not yet met your group's waiting period:	<input type="text"/>
3.	Please explain any enrollment waiting period your company may have:	

I certify that the foregoing information is true and complete to the best of my knowledge and belief. I understand that false and/or incomplete responses or statements may result in cancellation or recession of coverage. Anthem Blue Cross and Blue Shield of Connecticut reserves the right to request any reasonable documentation from firms, subscribers, or dependants in order to verify eligibility.

Name: _____ Title: _____

Signature: _____ Date: _____