

Independence Blue Cross 1901 Market Street Philadelphia, PA 19103

SMALL EMPLOYER CERTIFICATION

Group Name:					
Group Contact :					
Group Address:	(Street, including Department, Suite or Floor)				
	(City)	(State)	(Zip Code)		
Telephone:	()	Fax: ()			
pe of Business:	·	EIN#:			
Check One:	VAILABLE AND ONE OF THE FOLLOWING CIRCUMSTANCES EXIST: Newly formed company as of: Date Pennsylvania Unemployment Compensation Tax Form (UC-2A) has not been filed yet. I understand that I must submit a copy of our next UC-2A to my Administrator within 90 days.				
	, , , , , , , , , , , , , , , , , , ,	usiness or non-profit entity that am enclosing additional docum	nentation as proof		
An "eligible emplo	oyee" is any of the followi				
• An owner or p	partner actively engaged i	in the business.			
 A full-time em 	ployee of the business w	orking at least 20 or more hours	s a week.		

- A part-time employee, as long as <u>all</u> part-time employees are covered (the decision of whether to provide coverage for this class of individuals is at the discretion of the employer).
- Active over Age 65 employees and retirees to the extent that such retirees are covered pursuant to the employer's established written retiree program. However, groups consisting exclusively of retirees are not eligible for Independence Blue Cross Coverage.

All employees must be listed on the back of this form, regardless of their coverage status.



Please list <u>ALL</u> employees. Return this form with the Group Enrollment Form and completed individual applications. Please use the following letters to indicate status.

Social Security No.

F: Full-time employee who works 20 or more hours per week

P: Part-time employee who works less than 20 hours per week

T: Temporary (or) Seasonal employee

Name of Employee

R: Retiree employee

Date of

Employment

Hours

Worked

per Week

Status

C: Cobra

Please attach additional sheets if more employees must be listed.							
Total # of Eligible Employees							
Total # of Eligible Employees applying							
Total # of Eligible Employees waiving signed waiver form must be submitted							
I/We certify that I/we have responded to this form truthfully and to the best of my/our knowledge, and that any attempts to become eligible for the program through fraud or other material misrepresentations by me/us may result in termination of such contract and possible criminal prosecution. I/we hereby authorize Independence Blue Cross and Pennsylvania Blue Shield to make reasonable investigation and to obtain any documents necessary to verify the information provided. By signing below, I/we have read and understand the statements.							
Signature of Officer, Partner or Owner	Title	Date	_				
Print Name of Officer, Partner or Owner							
Signature of Witness or Administrator (Broker / Association)							

BOTH SIDES OF THIS FORM MUST BE COMPLETED.

Independence Blue Cross offers product directly, through its subsidiaries Keystone Health Plan East and QCC Ins. Co. and with Pennsylvania Blue Shield. Independent Licensees of the Blue Cross and Blue Shield Association.

