Independence Blue Cross

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:** (___) _____

Type of Business: _____ **EIN#:** _____

ONLY USE THIS FORM IF A PENNSYLVANIA UNEMPLOYMENT COMPENSATION TAX FORM (UC2A) IS NOT AVAILABLE AND ONE OF THE FOLLOWING CIRCUMSTANCES EXIST:

Check One:

☐ 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.

☐ Family owned business or non-profit entity that does not file UC-2A with State. I am enclosing additional documentation as proof of business.

An "eligible employee" is any of the following:

- An owner or partner actively engaged in the business.
- A full-time employee of the business working at least 20 or more hours 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 ALL employees. Return this form with the Group Enrollment Form and completed individual applications. Please use the following letters to indicate status.

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
R: Retiree employee
C: Cobra

Name of Employee	Social Security No.	Date of Employment	Hours Worked per Week	Status

Please attach additional sheets if more employees must be listed.

Total # of Eligible Employees	
Total # of Eligible Employees applying/enrolling for health benefits coverage	
Total # of Eligible Employees waiving health benefits coverage. A copy of the card or signed waiver form must be submitted. (Only allowed to Opt-Out for Contributory plans)	

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.

Form # 7107- PA Small Employer Cert.
12/2003