

Independence Blue Cross 1901 Market Street Philadelphia, PA 19103

SMALL EMPLOYER CERTIFICATION

Group Name:				
Group Contact :				
Group Address:	(Street, including Depart	tment, Suite or Floor)		
	(City)	(State)		(Zip Code)
Telephone:	()	Fax: (`	
Type of Business:	!	EIN#: _		
(UC2A) IS NOT AN	Pennsylva has not be our next U		ation Tax Fo t I must sub- nin 90 days. tity that does I documenta	orm (UC-2A) mit a copy of s not file UC-
An "eligible emplo	oyee" is any of the f	following:		
An owner or p	eartner actively eng	aged in the business.		
A full-time em	ployee of the busin	ness working at least 20 or mo	re hours a w	reek.
-		s <u>all</u> part-time employees are or or this class of individuals is a	•	

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

C: Cobra

R: Retiree employee

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

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.

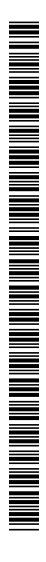
By signing below, I/we have read and understand the statements.

Signature of Officer, Partner or Owner	Title	Date	

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.



Print Name of Officer, Partner or Owner