Small Employer Certification Form

Pursuant to Connecticut Public Act 90-134 ("PA90-134"), as amended, carriers doing business in the small employer market in the State of Connecticut are responsible for determining if an employer group meets the eligibility criteria for small employers (1-50) employees nationally). The guaranteed issue and renewability provisions of PA90-134 and ConnectiCare's Underwriting Guidelines are contingent upon this criteria being met. Certification of eligibility is required upon initial application and prior to renewal.

Total number of full time eligible employees ______________

Total number of spousal waivers ______________

Total number of Medicaid/Medicare/Parental Waivers ______________

Total number of retirees ______________

Other waivers (list other coverage) ______________

Total enrolling ______________
(Full time employees working 30 hours or more a week)

Name of employees submitting waivers Waiver Reason (See above)

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I certify that the above information is correct and that:

a. the above mentioned company is a firm, corporation, or partnership actively engaged in business for at least three consecutive months, who on a least fifty percent of its working days during the preceding twelve months, employed no more than fifty employees, the majority of whom were employed within the State of Connecticut.
b. all eligible employees are covered by worker's compensation insurance, except when exempt under applicable law, and
c. all eligible employees have equal access to ConnectiCare and the company contributes at least fifty percent of the single premium on behalf of all eligible employees.

I understand that the provision of PA90-134, as amended, ant the underwriting guidelines of ConnectiCare shall determine eligibility of the employer, employees and their dependents. I understand that failure to provide ConnectiCare with timely proof of employer and/or employee eligibility shall result in termination of coverage.

I also 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 rescission of coverage. ConnectiCare reserves the right to request any reasonable documentation from firms, subscribers, or dependents in order to verify eligibility.

Name: ______________________________ Title: ______________________________

Company Name: ______________________________ Date: ______________________________

Address: ____

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Signature: ____

Please return this Certification Statement with your new case or renewal paperwork. Thank you in advance for your cooperation.

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