

Massachusetts Small Employer Certification Form

Pursuant to Massachusetts provision of Chapter 176J of Insurance laws, carriers doing business in the small employer market in the State of Massachusetts 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 Chapter 176J and ConnectiCare's Underwriting Guidelines are contingent upon these 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) |
|--------------------------------------|---------------------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

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 Massachusetts.
- 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 Chapter 176J, as amended, and 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: _____

Signature: _____

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



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