



**BlueCross BlueShield
of Vermont**

Independent Licensees of the Blue Cross and Blue Shield Association.



**SMALL GROUP
CERTIFICATION**

COMPANY NAME: _____ ADDRESS: _____

GROUP #: _____

COMPANY MINIMUM ELIGIBILITY POLICY FOR HEALTH INSURANCE: _____ Hours per week
(Eligibility requirement must be no less than 17.5 hours per week, and at least one employee must work 30 hours per week and must enroll in the plan.)

I. EMPLOYEE CENSUS

Vermont’s Act 52 defines a Small Employer as an employer who, on at least 50% of its working days during the preceding calendar quarter, employed at least one and no more than 49 employees. The definition of Small Employer includes self-employed persons, who must work at least 30 hours per week to be eligible.

As part of your Small Group Certification, please complete all of the information on the Employee Census Information requested on the back of this form. If additional lines are needed, please include additional copies of the Census

II. PROOF OF BUSINESS/INSURANCE

When returning your Small Group Certification Form you MUST include BOTH of the following:

- Evidence of coverage through spouse for all eligible employees declining coverage
(Copy of Spousal Insurance Card)
- Employer’s Quarterly Wage and Contribution Report (please indicate terminated, seasonal and part-time employees and please white-out any proprietary information)

If you are not required to file an Employer’s Quarterly Wage and Contribution Report (Form C-101) with the Vermont Department of Employment and Training, or with any other state in which you do business, please submit one of the following: IRS Schedule C (Proprietorship); IRS Schedule SE (Self Employed); or IRS Schedule K-1 (Partnership or “S” Corporation)

III. CERTIFICATION

I verify that I have completed the Census information requested on the back of this form.

I certify that I qualify as a Small Employer, OR that I employ more than 49 employees, with fewer than 50 enrolled on the group-sponsored health plan. I further certify that the majority of my employees work in the State of Vermont, and that if I am required to file an “Employer’s Quarterly Wage and Contribution Report” with the Department of Employment and Training I have attached a copy of the most recent one to this form.

I certify that the information provided above is true and complete. I understand that if the above information is incomplete, untrue or is not provided in a timely manner, then group health benefits do not have to be offered or continued.

Please sign and date:

Signature of Officer, Partner or Owner _____ Date _____

Signature of Officer, Partner or Owner _____ Date _____

IF ALL OF THE REQUESTED INFORMATION IS NOT COMPLETE, THIS FORM WILL BE RETURNED TO YOU.

EMPLOYEE CENSUS INFORMATION

Please complete the following census OR include all of the requested information on the attached copy of your most recent Quarterly Wage and Contribution Report. This census must include current active employees, terminated employees included on the insurance under COBRA, Vermont continuation coverage and retirees. Your list of current active employees should include: the owner(s), officer(s), manager(s) and employee(s) of the employer; the partners, if the employer is a partnership; and the self-employed individual, if the business is a sole proprietorship.

Please use the following letters to complete the "EMPLOYMENT STATUS" column below:

- F** Full-time employee
- P/E** Part-time or seasonal employee, eligible for benefits
- P/I** Part-time or seasonal employee, ineligible for benefits
- U** Union employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement
- C** Continuee under State or Federal Law (COBRA or Vermont continuation coverage)
- R** Retiree, eligible for benefits
- T** Terminated employees

EMPLOYEE NAME: LAST NAME, FIRST INITIAL	COVERED BY SPOUSE? N or Y *	HIRE DATE (IF WITHIN PAST 12 MOS.)	NUMBER OF HOURS WORKED PER WEEK	EMPLOYMENT STATUS	STATE WHERE EMPLOYED (IF OTHER THAN VT.)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					

** Eligible employees who decline coverage because they are covered under their spouses' health insurance plans MUST submit photocopies of their spouse's I.D. Cards.*