Affiliated Physicians & Employers Health Plan
A NJ Self-Insured MEWA

EMPLOYER CERTIFICATION

Practice Name and Address:	**Telephone**:	**Renewal Date**:
		/ /
	Fax:	
	Account #: **(if a current customer):**	

Please indicate your office's individual waiting period before medical coverage can begin. Select only one for each.

New Hire: __1st of the month following date of hire; __1st of the month following 30 days; __1st of the month following 60 days

Rehire: __ 1st of the month following date of hire; __1st of the month following 30 days; __1st of the month following 60 days

If any class of employee waiting period is waived, please list classes below *(Example: Medical coverage begins immediately for "Physicians – No Waiting Period"):*_____

FOR EMPLOYERS WITH MULTIPLE SITES

If you have more than one site (office), other than the address above, please list out your multiple sites and total employees at each site:

Site (Office) Location (City/State)		Number of Employees in each site			
CITY	**STATE**	Full-time	Part-time	Retired	Other

TOTAL EMPLOYEE CALCULATION

Total Employees

A **Total # Full-Time Eligible Employees* (Refer to Underwriting Guidelines)** _____ **(A)**

B **Total # Part-time Employees (Refer to Underwriting Guidelines)** _____ **(B)**
(does not include Per Diem employees)

C **Total # Employees (A+ B):** ═══ **(A+B)**

Total Benefit Eligible Employees ***(Based on "A" Total above)***

Total # Eligible Employees applying/enrolling for health benefits coverage. _____

Total # Eligible Employees waiving health benefits coverage with other coverage
through a spouse, other than individual coverage; or any other Health Benefits Plan offered by the employer. _____

Total # Eligible employees waiving health benefits coverage without other coverage
through a spouse, other than individual coverage; or any other Health Benefits Plan offered by the employer. _____

Federal Law – Eligible Employees ***(Based on "C" Total above – Includes Part-Time)***

Is your firm subject to the requirements of the federal COBRA law? ☐Yes ☐No
(You *may* be subject to the law if you employed 20 or more employees during 50% or more of the working days during the previous calendar year.)

Is your firm subject to Working Aged Provisions of federal law (TEFRA/DEFRA)? ☐Yes ☐No
(You *may* be subject to the law if you employed 20 or more employees for 20 weeks in the current or prior calendar year.)

* An **Eligible Employee** as defined in the Underwriting Guidelines.

CERTIFICATION AS A SMALL EMPLOYER (IF APPLICABLE), IN THE STATE OF NEW JERSEY

"Small Employer" means, in connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that:

- employed an average of at least two, but not more than 50, Eligible Employees on business days during the preceding Calendar Year, and
- employs at least two Eligible Employees on the first day of the Plan Year, and
- the majority of the Eligible Employees are employed in New Jersey.

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If you're total in **part A** on the previous page is **between 2-50**, you qualify as a Small Employer and must check the boxes **D and F** and sign below. If you're total in **part A** on the previous page is **greater than 50 or equal to 1**, check boxes **E and F** and sign below.

D ☐ **I certify that I qualify as a Small Employer in the State of New Jersey.**

OR

E ☐ **I certify that I do not qualify as a Small Employer in the State of New Jersey, based on the previous definition.**

AND

F ☐ **I certify that the information provided the Affiliated Physicians and Employers Health Plan is true and complete**. I understand that if the above information is not complete or is not provided in a timely manner, then health benefits coverage does not have to be offered or continued. I further understand that incomplete or untrue information may void health benefits coverage.

Signature of Officer, Partner or Owner: _____Title:_____Date:_____

Print Name of Officer, Partner or Owner: _____

Signature of Witness: _____ Date:_____

Any person who includes any false or misleading information on an application or enrollment form or certification for a health benefits plan is subject to criminal and civil penalties, as well as termination of all health coverage.

EMPLOYEE CENSUS INFORMATION

Please include the following persons in the following list:

a) employees, owners, partners, officers, and independent contractors who are actively working for the employer on a regular basis, and are paid by the employer on a regular basis, whether or not they are eligible to be covered.

b) employees, owners, partners, officers, and independent contractors who are not working, but who are currently covered under the employer's health benefits plan for reasons such as continuation of coverage or total disability.

Please use the following letters to indicate Status:

O: Owner, partner or officer
F: Full-time employee
P: Part-time employee
D: Totally Disabled employee
W: Waiving Coverage (has coverage through spouse, Medicare or other source)
I: Independent Contractor
T: Temporary employee
Y: Per Diem employee
C: Continuation of Coverage under State or Federal law
X: Does not want Coverage

Employee Name & Title (Example: John Smith -Doctor)	Date of Birth (mo,dy,yr)	Gender (M,F)	Date of Hire (mo,dy,yr)	Type of coverage (Single, EE/Child(ren), EE/Spouse ,Family)	Hours Worked per week	Status (F,P,D,W,I,T,C,X, Y)
PLEASE ATTACH A COPY OF CURRENT CENSUS TO INCLUDE ALL ELIGIBLE EMPLOYEES, PART TIME AND WAIVERS						

If additional space is needed, attach a separate sheet.

1) Please note that you can offer multiple plans alongside this plan and therefore can request a quote for 1 or 2 or 3 or 5 plans.

Call us if you have any questions at 833-MEWANOW (833-639-2669).