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.** Census must include current active employees, terminated employees included on the insurance under VIPER/COBRA, and retirees. **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 (who must work at least 30 hours per week), if the business is a sole proprietorship. The individuals on this list should match those listed on the quarterly wage report that you are providing to us.**

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 (VIPER/COBRA)
R: Retiree, eligible for benefits
T: Terminated employees

EMPLOYEE NAME: LAST NAME, FIRST INITIAL	COVERED BY OTHER INSURANCE N or Y*	HIRE DATE (IF WITHIN PAST 12 MOS.)	NUMBER OF HOURS WORKED FOR 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 another group health benefit plan as a spouse or dependent, Catamount Health, Medicaid, The Vermont Health Access Plan or Medicare MUST submit photocopies of the other insurance ID cards.*

SMALL GROUP CERTIFICATION

GROUP NAME ______________________

PHYSICAL ADDRESS ______________________

GROUP NUMBER ______________________

MAILING ADDRESS ______________________

NUMBER OF EMPLOYEES ON PAYROLL ______________________

TAXPAYER ID NUMBER ______________________

GROUP E-MAIL ______________________

COMPANY MINIMUM ELIGIBILITY POLICY FOR HEALTH INSURANCE IS:

Hours per week __________ ***(required)***

(Eligibility requirement must be no less than 17.5 hours per week and no more than 40 hours per week. 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 50 employees. For purposes of this calculation, each person working at least 30 hours per weeks is counted as an employee.

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 the following:

- **Evidence of coverage** (copy of other insurance card) through another insurance plan as a spouse or dependent, Catamount Health, Medicaid, The Vermont Health Access Plan or Medicare. Evidence of coverage is only required for a full-time eligible employee **not** enrolled in this coverage.
- **Employer's Quarterly Wage and Contribution Report** (please indicate terminated, seasonal and part-time employees and the number of hours worked per week by each employee. You may remove Social Security numbers and financial 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 and have 50 or fewer employees working 30 or more hours per week. 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 report to this form or I am a self-employed proprietor and I have attached one of the following: IRS Schedule C (Proprietorship), IRS Schedule SE (Self-Employed) or IRS Schedule K1 (Partnership or "S" Corporation).

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.

If all of the requested information is NOT complete, this form will be returned to you.

Please sign and date.

Signature of Officer, Partner or Owner ______________________ Date ______________

Signature of Officer, Partner or Owner ______________________ Date ______________

Send original to— Blue Cross and Blue Shield of Vermont
P.O. Box 186, Montpelier, VT 05601-0186