ELIGIBILITY CERTIFICATION FORM

Employer Name: _____

Employer Address: _____

This form, along with your quarterly state wage and tax report, will be used by NHP/NHIC to determine if your group satisfies NHP/NHIC's minimum eligibility and participation requirements.

Use the lines provided on the reverse of this form to:

- List anyone who does <u>not</u> appear on your last filed quarterly state wage and tax report

  OR,

  (If you have no wage and tax statement)
- List ALL individuals who are either:
  - Actively working for you, (even if they have other creditable coverage), OR
  - Not working, but who are currently covered under your group health plan for reasons such as state and/or federal continuation of coverage or total disability, etc.

Please use the following Status Codes to indicate the status of each individual listed:

<u>STATUS CODES</u>

SP	Sole Proprietor *
BO	Business Owner *
PA	Partner *
MLLC	Member, Limited Liability Company *
FT	Full Time Employee (working 30 or more hours per week on a permanent basis)
PT	Part Time Employee (working <30 hours per week but > minimum hourly requirement)
ECO	Employee on Continuation, state or federal **
DCO	Dependent on Continuation, state or federal **
WA/OQC	Employee Waiving coverage due to enrollment in another group plan sponsored by another employer (Other Qualifying Coverage) **
WA/O	Employee Waiving coverage due to any Other reason ***

*	*Eligible if included as an employee under a health benefit plan*
**	*Eligible but not included for the purposes of determining minimum participation*
***	*Employees coded with this status need to complete a Waiver of Coverage Form. Where applicable, the name of the other insurance carrier must be included in the space provided below.*

<u>(Ineligible Categories)</u>

FTP	Full Time Probationary
PT	Part Time
PTP	Part Time Probationary
TE	Temporary Employee
SE	Seasonal Employee
TD	Totally Disabled Employee
RE	Retired Employee
WA/DC	Employee Waiving coverage due to enrollment in another group plan sponsored by you (Dual Choice)

(Lines for listing employees are provided on reverse)

Employee Name	Date of Employment	Hours Worked /Week	Hours Worked /Year	Status Code	Annual Compensation	Name of Other Insurance Carrier (where required)
1.						
2.						
3.						
4.						
5.						
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27.						

If additional space is needed, attach another sheet of paper.

Reminder: A waiver form will be required for any employees and/or their dependents that are waiving any of the coverages available under your plan.

- I certify that I have read this document and that the information provided is accurate and complete.
- I certify that all employees actively working for me are compensated in a manner that complies with all applicable state and federal minimum wage requirements.
- I certify that the information provided can be substantiated by business documents. Upon request, I agree to provide the documentation requested to establish that eligibility and participation requirements are met at all times coverage is provided by (i.e. Wage and Tax form, Taxpayer I.D. numbers, W-2 forms, LLC or incorporation papers, payroll records, etc.)

Signature of Employer: _____ Title: _____

Printed Name of Employer: _____ Date: _____