SMALL GROUP RECREDENTIALING FORM

Please read all instructions and fill in the information requested below. Return via mail or fax to:

Empire BlueCross BlueShield
Small Group Recredentialing
15 MetroTech Center 6th Floor
Brooklyn, NY 11201
Fax: 1-718-312-6013 or 1-718-312-6012
If you have any questions regarding this form, please call **1-631-577-6099**.

SECTION I — All Groups Must Complete

A. Employees: Based on current payroll, please indicate the total number of active employees in each category below and answer the questions as they relate to your business. (Do not include employees working in foreign countries who are offered socialized medicine and are thus not eligible for Empire coverage. Examples of countries offering socialized medicine include, but are not limited to, Australia, Canada, France, Germany, Great Britain, Italy, Spain and Switzerland).

Count Each Owner or Employee Only Once

Category*	**# of People**	**Please answer as applies**
Full-Time Employees (Non-Union)		
Part-Time Employees (Non-Union)		
Union Employees		# of Union Employees enrolled in your group's Empire coverage: _____

B. Retirees: How many Retirees are covered under this plan? _____
Does the company contribute at least 50% of premium for all retirees covered on this plan? **Yes** / **No** (circle one)

C. Owners: Number of Business Owners* enrolled in your group's Empire coverage _____
IMPORTANT: If you have 1 enrolled owner and no other Full Time (non-union) Employees or enrolled Union Employees covered on this group, you must submit documentation to establish that you have at least 1 additional eligible Business Owner*. See reverse side for required documentation.
* See reverse for definitions

SECTION II — If the only Empire Medical Product that your group offers is HMO or Direct HMO, skip to Section III

A. Please indicate the total number of full-time eligible employees included above who **are not** covered under this plan and **are** covered through their spouse's coverage. _____

B. Does your company currently have employees enrolled in medical or medical/hospital coverage from another insurance carrier? **Yes** / **No** (circle one)

C. If applicable, please indicate any other classes of employees not eligible for Empire coverage (i.e. management, hourly, etc.)

_____ _____
Class Description # of ineligible employees

SECTION III — CERTIFICATION — All Groups Must Complete

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

I ensure, to the best of my knowledge, that only those employees who are eligible for coverage under New York State law are currently enrolled in the Empire benefit product to which this Form applies and that all information provided is accurate to the best of my knowledge.

_____ _____
Signature Date

_____ _____
Print Name Title Federal Tax Identification Number

_____
Company Name / Group Number

Please complete carefully. Incomplete or inaccurate forms will not be accepted.

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EMPLOYEE CATEGORY DEFINITIONS:

Full-Time Employees: Non-Union employees working 20 or more hours per week.

Part-Time Employees: Non-Union employees working less than 20 hours per week.

Union Employees: Full- or Part-Time employees who are members of a Union.
Please Note: Full-Time Union Employees are eligible to enroll if they are not covered by a union-sponsored health plan. (Union roster may be required as proof.)

Business Owner: A person that has a legal ownership interest in the small group's business but who is not counted as an employee of the business. The ownership interest must not be acquired or maintained simply for the purpose of obtaining health insurance coverage.

To establish owner eligibility: Provide one of the following: (i) official payroll listing, (ii) NYS-45 Quarterly Combined Withholding, Wage Reporting and Unemployment Insurance Return, listing owner; (iii) Form 1065 (Schedule K-1), Partner's Share of Income, Deductions, Credits, etc.; (iv) Form 1040 (Schedule C), Profit or Loss From Business; (v) Form 990, Return of Organization Exempt From Income Tax; (vi) Form 1120, US Corporate Income Tax Return; or other acceptable tax documentation that substantiates proof of eligibility.

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