



Recertification of Eligibility - Connecticut

Recertification of small employer eligibility is required as part of your renewal. Please complete the following information and attach the most recent state quarterly tax and wage report (CT-UC2/5A or Sole Proprietor-Schedule C):

Group Name: _____ Group Number: _____

Group Renewal Date: ____/____/____

Pursuant to the state laws of Connecticut carriers need information from employer groups to determine if the groups qualify as small employers under the law. The guaranteed issue and renewability provisions of PA 90-134 (CT) and ConnectiCare's underwriting guidelines are contingent upon this criteria being met. **Certification of eligibility is required upon initial application and prior to renewal. Receipt of a renewal package does not confirm that you have recertified the eligibility of a small group and its employees.**

The Connecticut statutory definition of a small employer is any person, firm, corporation actively engaged in business for at least three consecutive months which, on at least fifty percent of its working days during the preceding twelve months, employed no more than 50 eligible employees (nationwide), the majority of whom were employed within the state of Connecticut. Eligible employees shall not include employees covered pursuant to collective bargaining, companies which are affiliated companies or which are eligible to file a combined tax return shall be considered one employer. Section 33-840 defines an affiliated company as one which controls, is controlled by, or is under common control with (directly or indirectly) another company.

1. **DO YOU OFFER HEALTH COVERAGE TO EMPLOYEES WORKING 20-29 HOURS?** YES _____ NO _____

2. **TOTAL NUMBER OF FULL-TIME EMPLOYEES**

List only full-time employees working 30 hours or more per week, including owners, and spouses that work full-time for the company as of the group's renewal effective date. _____

3. **TOTAL NUMBER OF FORMER EMPLOYEES ON COBRA/STATE CONTINUATION** _____

4. **TOTAL NUMBER OF PART TIME EMPLOYEES WORKING LESS THAN 20 HOURS** _____

5. **TOTAL NUMBER OF PART-TIME EMPLOYEES WORKING 20 – 29 HOURS** _____

6. **TOTAL NUMBER OF SEASONAL EMPLOYEES** _____

Do not include seasonal employees under full time or part time status

I certify that the foregoing information is true and complete to the best of my knowledge and belief. I understand that false or incomplete responses or statements may result in cancellation or rescission of coverage. ConnectiCare reserves the right to request any reasonable documentation from firms, subscribers or dependents in order to verify eligibility. **Rates may be subject to change depending on the certified eligibility information.**

Employer Name: _____ Employer Signature: _____ Date: ____/____/____

Broker Name: _____ Broker Signature: _____ Date: ____/____/____

Please fax this recertification statement and applicable quarterly wage report to: **(860) 678-5272**

Or Mail to: **ConnectiCare Small-Group Administration Department**

175 Scott Swamp Road, P.O. Box 4050, Farmington, CT 06034-4050

If you have any questions please call **1-800-723-2986**

Coverage is provided by and services are administered as follows: In Connecticut: Group HMO and POS coverage is underwritten by ConnectiCare, Inc.; FlexPOS, PPO coverage, ASO/Self-funded services, and Dental products are administered or underwritten by ConnectiCare Insurance Company, Inc.

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