# Group Certification Document

Please complete this document and have it signed by the group's authorized representative.

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

1. **Employer Size:**

   Blue Cross® Blue Shield® of Arizona (BCBSAZ) Plan effective date: _____/_____/_____

   We need to know the average number of total employees you employed on business days during the calendar year that precedes your next plan effective date. When counting, you must include all employees, including part-time and seasonal workers, regardless of whether the employee was eligible for coverage under the plan.

   What was the average number of total employees on business days during the calendar year prior to your effective date? _____

   **Important Note —** If you are completing this form prior to the end of the calendar year and your plan effective date is the following calendar year, please provide your estimated number and then reevaluate at the end of the year. If your average total employee number has either moved above 50 or below 51, you must immediately notify Sales Support at **smgrpre@azblue.com.**

2. **Eligible Employee Verification for Small Employers (Accountable Health Plan-AHP)**

   On a typical business day how many employees are eligible for health benefit plan coverage?

   Arizona Eligible Employees: _____ Non-Arizona (U.S. and worldwide) Eligible Employees: _____

3. **Employer Verification of Total Employees**

   How many total employees does your company have regardless of benefit eligibility?

   Arizona Employees: _____ Non-Arizona (U.S. and worldwide) Employees: _____

4. **Medicare vs. Employer as Primary Coverage for Working Aged**

   Did your company have 20 or more full- and part-time employees, (count all employees throughout the U.S.), for 20 or more calendar weeks during the:
   Current calendar year (Check one): ☐ YES ☐ NO Preceding calendar year (Check one): ☐ YES ☐ NO

   Please Note: If you answered "no" in "preceding calendar year," skip question 5.

5. **Medicare vs. Employer as Primary Coverage for Disabled Individuals**

   Did your company have 100 or more full- and part-time employees, (count all employees throughout the U.S.), for **at least** 50% of the working days during the preceding calendar year? (Check one): ☐ YES ☐ NO

6. **Upcoming Plan Year Employer Contribution Strategy**

   What percentage of the premium rate will be paid by the employer?

   Employee Rate % _____ Dependent Rate % _____

I understand that BCBSAZ is relying on my answers to the questions. I affirm that these answers are true to the best of my knowledge and belief. I will promptly update BCBSAZ if any of the information above changes. For grandfathered coverage, I understand that certain changes in employer contribution may trigger a loss of grandfathered status and that I must notify BCBSAZ of such changes as BCBSAZ cannot make that determination. By the signature below, Employer hereby authorizes BCBSAZ to release to Employer's Broker of Record a copy of the Group Master Contract or Administrative Service Agreement and/or any and all rate and/or fee information. I represent that Employer employs and enrolls at least one common law employee as required in order to sponsor a group health plan. (Please visit http://www.irs.gov/Businesses/Small-Businesses-&-Self-Employed/Employee-Common-Law-Employee for more information on common law employees.) If you do not have at least 1 common law employee enrolling on your group health plan please contact your BCBSAZ Client Service Manager.

Healthcare reform proposals include provisions for increases on fees and taxes paid by insurance companies which may result in an increase in your rates. Notwithstanding any other provisions in this rate proposal, if the government imposes a new tax or fee on insurers, the rate set forth in this rate proposal may be adjusted to include, even retroactively, such taxes and fees.

_____ / /

Authorized Signature | Please Print | Date

_____

Employer Name

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