



Employer Census Certification



EMPLOYER/PLAN SPONSOR NAME

Please list **all** employees who work an average of twenty (20) or more hours per week and provide the requested information. Include employees who are waiving coverage and those who are on COBRA. In lieu of this form, a computer generated listing with all requested information will be accepted. Use additional sheets as needed.

Minimum participation requirements, excluding employees who waive coverage because of other health insurance coverage are: 2 - 5 employees, 100% must enroll; over 6 employees, 75% must enroll.

- New employees are eligible after a waiting period of (select one): No Waiting Period 30 Days 60 Days 90 Days 180 Days 365 Days Other - please list (maximum 365 days): _____
- Employees must work a minimum of _____ (minimum 20 and maximum 40) hours per week to be eligible for coverage.

*Coverage Codes: EO – Employee Only EC – Employee & Child(ren) WC – Waived Coverage: Other Coverage
 ES – Employee & Spouse EF – Employee, Spouse & Child(ren) WU – Waived Coverage: Reason Unknown
 NE – Not Eligible WAIT – Waiting Period Not Completed

Employee Name	Date of Birth mm/dd/yyyy	Hours Worked Per Week	Date of Hire mm/dd/yyyy	*Coverage Code	State of Residence (Complete if not Montana)	COBRA Member Check if Yes
1.						
2.						
3.						
4.						
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16.						

(Continue list on the other side, if needed.)

I hereby certify this data, and any attached additional sheets, are accurate and complete. I understand that false statements regarding this information may result in premium adjustments and/or termination.

Employer Signature _____ Date _____

Title _____ Agent/Producer Signature _____

Employee Name	Date of Birth mm/dd/yyyy	Hours Worked Per Week	Date of Hire mm/dd/yyyy	*Coverage Code	State of Residence (Complete if not Montana)	COBRA Member Check if Yes
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