EXHIBIT CC: 20xx

New Jersey Small Employer Health Benefits Program **Carrier Small Employer Market Share Report**

This report must be completed in accordance with the provisions of N.J.A.C. 11:21-10, and certified by the Chief Financial Officer or other duly authorized officer of the Carrier. This report must be completed and returned on or before March 1, 20xx.

	rier Informa	tion	
Carrier's Name:			
Carrier's NAIC Number:			
group health benefit lines provided below service corporation organization located that is affiliated w	s plans in fow. However or medical s in the State with an insure	ne combined Market Share Report, listing all aforce for small employers in the preceding caler, any insurance company, health service corporation that is an affiliate of a hear, and any health maintenance organization local rance company, health service corporation, lorporation shall submit separate Market Share Response.	ndar year in the oration, hospital lth maintenance ated in the State hospital service
Affiliated Carriers:			
(Name and NAIC Number)			
(Traine and Traine Traineer)			
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Part B. Pers Name: Title: Phone:	sonal Respor	Fax:	
Email:		Fax:	
Mailing Address:			
Maining Address:			_
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		Information for 20xx	ф
1. Net earned premium for all small employer group health benefits plans in 20xx:			
2. Less refunds paid in 20xx:		\$	
3. Assessable Net Earned Premium (1-2=3):			\$
I certify that I am the	provided in	ncial Officer or other duly authorized officer of the this Report is accurate and complete, and has be N.J.A.C. 11:21-10.	
Printed Name:			
Title:			
Signature:			Date:

Signature: