EXHIBIT CC

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. Reports must be completed and returned on or before April 15, 1994 and by **March 1** of each year thereafter. Completed Reports must be returned to SEH Program Administrator as set forth in N.J.A.C. 11:21-1.3.

Part A. Carrier Information

1. Carrier's Name:

   _____

2. Carrier's NAIC Number:

   _____

3. Is the above named Carrier as affiliated Carrier?
   _____Yes ____No

   a. If Yes, please list all Carriers with whom the above named Carrier is affiliated. List only those affiliates that had group health benefits plans in force for small employers in the preceding calendar year.

Name	**NAIC#**

Part B. Personal Respondent Information

1. Name:

   _____

2. Title:

   _____

3. Mailing Address:

   _____

   _____

4. Telephone No. _____ FAX No. _____

Part C. Calendar Year Information for 199

Net earned premium for all small employer group health benefits plans: $ _____

Part D. Certification

I certify that information provided in this Report is accurate and complete, and has been prepared in accordance with the provisions of N.J.A.C. 11:21-10.

_____ _____ _____

Signature **Title** **Date**