Employer Large Group Size Attestation

Instructions for Completing this Attestation

As of 2016, per Affordable Care Act (ACA) guidelines, the definition of a Large Group is one that has more than 100 Full-time Equivalent (FTE) employees. This certification is required by MVP Health Care® for all groups who may expect to enroll less than 150 employees for coverage at the time a proposal or renewal is requested, and for accounts of any size with multiple Tax Identification Numbers (TIN).

A Group Size Attestation is required on an annual basis, prior to the finalization of renewal coverage and rates.

This form does not constitute legal or financial advice.

Section 1: Group Information

(Please print)

Group Name

Group No.

Group Renewal Date

All Tax Identification No(s). (TIN) Associated with Group

Employer Health Benefits Administrator Email

Section 2: Separate Entities with Multiple Tax ID Numbers

Only complete this Section if this circumstance applies to the Group. Group size for groups under common ownership is determined based upon the total Full-Time Equivalents (FTE) for all entities. To combine separate groups into one employer group for group insurance purposes, the commonly owned businesses or affiliates must qualify as a single employer under subsection (b), (c), (m), or (o) of the Internal Revenue Service section 414.

If any of the following conditions apply, tax documentation certifying that at least 80% common ownership may be required upon request.

If any of the above conditions apply, MVP may, at its discretion, require the employer to submit documentation demonstrating common ownership under section 414.

Acceptable tax forms are: (1) IRS Form 851 (Affiliations Schedule) with the names of all entities or (2) IRS Form 1065 (Schedule K-1).

Select all of the following conditions that apply to this Group.

- ☐ **Multiple Tax ID Numbers are listed in Section 1**
- ☐ **This Group owns another entity**
- ☐ **This/These Groups are owned by another entity**
- ☐ **This Group is one of multiple groups that are owned by the same entity/entities**

Section 3: Employer Group Size Calculation

Solely for purposes of determining whether an employer is a large or small employer, the employer is required to calculate the number of Full-Time Equivalents (FTE) it employed **during the most recent rolling 12 months**, and count each such FTE as one full-time employee. Refer to the employee definitions below.

Common Law Employees are eligible for health Insurance coverage. Common law employees are defined as anyone who performs services for an employer as long as the employer has financial and/or behavioral control for these employees. Leased employees, 1099 employees, and union employees are considered employees under this definition and should be included in the group size count.

Retirees are not "employees" and are not counted in group size.

Part-Time Employees are those who work less than 30 hours per week and are counted using the FTE counting method. To convert the number of part-time employees to an FTE number, the average monthly aggregate number of hours worked for part-time employees is divided by 120. Part-time hours are capped at 120 hours per employee, per month.

COBRA participants are not included in the FTE calculation for determining group size.

To assist you in calculating your group's part-time FTEs, visit **irs.gov/affordable-care-act** and select *Employers*, then *Determining if an Employer is an Applicable Large Employer.*

Total Number of Full-Time Employees	+	**Total Number of Part-Time FTE* Employees**	=	**Total Number FTE Employees**	0

*The full-time equivalent employee counting method in 26 U.S. Code § 4980H(c)(2) must be utilized to determine group size. This method is the same calculation used to determine employer liability under the Shared Responsibility for Employers provisions of the Affordable Care Act (ACA) and Internal Revenue Code.

Group Name	*Group No.*

Section 4: Authorization

I hereby certify that the statements made on this Attestation are true and complete to the best of my knowledge and belief.

The Group acknowledges that MVP Health Care will rely on the information provided by the group, and that MVP Health Care at all times retains the right to require additional information regardless of group size. Failure to provide additional information may lead to termination of group coverage.

Unless otherwise prohibited by law, I consent to the receipt of electronic communications related to my MVP health plan at the email address I provided. I have read and agree to the details outlined in MVP's Electronic Disclosure, which is available at **mvphealthcare.com/privacy-notices** or by calling MVP at **1-800-TALK-MVP** (1-800-825-5687).

I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

The parties agree that this authorization may be electronically signed. The parties agree that the electronic signature appearing on this Recertification form is the same as a handwritten signature for the purposes of validity, enforceability, and admissibility.

I have read and agree to this authorization.

Employer Health Benefits Administrator Signature	*Title*	*Date*