Small Group Recertification

for Vermont Small Group Renewals

Please complete and submit all pages of this form.

Section 1: Group Information *(please print)*

Group Name	Group No.

Federal Tax ID No.	Federal Tax ID No.	Federal Tax ID No.	Federal Tax ID No.

Please provide a complete list of the names of the owners of this company, even if some owners are not taking coverage.

1 Name

2 Name

3 Name

4 Name

Section 2: Group Administration Details

See the attached Underwriting Guides for employee definitions and calculations.

Total Number of Employees—*both part-time and full-time*
(to determine Certification of Benefits for members over age 65)

Total Number of Full-Time Equivalent Employees
(to determine if Small or Large Group)

Does at least one employee taking coverage live, work, or reside in the MVP service area? ☐ Yes ☐ No
(If you are unsure of the counties and states covered within the MVP service area, contact your broker or MVP Account Representative)

Does your group have fewer covered employees living outside the MVP service area than covered employees living in the MVP service area? ☐ Yes ☐ No

Section 3: Separate Entities with Multiple Tax Identification Numbers

Only complete this section if you have separate entities with multiple Tax Identification numbers.

Group size for groups under common ownership is determined based upon the total Full-Time Equivalents for all entities. In order to combine separate groups into one employer group for group insurance purposes, MVP will require documentation that 80% of each entity is owned by the same individual or set of people. Please check if any of the conditions apply:

☐ Multiple Tax Identification Numbers are listed above.

☐ 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.

*If any of the above conditions apply, tax documentation certifying that at least 80% common ownership must be submitted with this Recertification. Acceptable tax forms are: (1) IRS Form 851 (Affiliations Schedule with the names of all entities **or** (2) IRS Form 1065 (Schedule K-1).*

Section 4: Group Contact Information

List all physical addresses for the business provided in Section 1.

Mailing Street Address	City	State	Zip Code

County	Phone No. ( )	Email Address

Billing Street Address ☐ Same as Mailing Address	City	State	Zip Code

County	Phone No. ( )	Email Address

Continued on page 2

Group Name	*Group No.*

Section 5: Health Benefits Administrator and Broker Information

Health Benefits Administrator Contact Name

Billing Contact Name

Broker/Agency Name

Section 6: Business Locations

Please list all business locations, even if located outside Vermont.

1 Street Address | City | State | Zip Code

County | Phone No. ( )

2 Street Address | City | State | Zip Code

County | Phone No. ( )

3 Street Address | City | State | Zip Code

County | Phone No. ( )

4 Street Address | City | State | Zip Code

County | Phone No. ( )

Section 7: Authorization

For a group health plan to be considered a "group health plan" under the Employee Retirement Income Securing Act (ERISA), there must be at least one common law employee enrolled as a contract holder. Pursuant to 29 CFR 2510.2-3(b), an "employee benefit plan" does not exist if no "employees" are covered by the plan. An "employee" does not include the owner(s) of a business or a spouse of the business owner.

_____
Employer Initials

By signing this document, you attest that your group has made MVP Health Care coverage available to all common law employees and that at least one common law employee is currently enrolled with one of your group sponsored health plans for the term of the benefit year. Please note that waivers of coverage including spousal waivers cannot be used to determine group eligibility.

_____
Employer Initials

MVP reserves the right to request your group's tax documents at any time throughout the year. Failure to produce requested documents could result in the termination of your group health insurance.

_____
Employer Initials

I certify that, to the best of my knowledge and belief, and under penalty of perjury, the information listed on this form is true and complete, including that the persons proposed for coverage work at least 20 hours per week or are otherwise eligible for coverage.

Continued on page 3

Group Name	*Group No.*

*(**Section 8: Authorization** continued from page 2)*

_____ ***Employer Initials***	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 $5,000 and the stated value of the claim for each such violation.

Employer Signature Date

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*Please fax all pages of this completed form to **518-836-3279**.*