Vermont Small Group Recertification

Instructions for Completing this Request

Submit all pages of this completed form and any required documents via email to your MVP Account Representative or by fax to **518-836-3279**.

Section 1: Group Information *(Please print)*

Group Name

Group No.

All Federal Tax ID No(s). (FEIN) Associated with Group

All Principal(s) of this Company

Name Title

Name Title

Name Title

Name Title

Section 2: Group Administration Details

For the purposes of the following questions, retirees and COBRA participants are not considered "employees" and should not be counted to determine group size. To convert the number of part-time employees to a full-time equivalent (FTE), the 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.

What is the total number of part-time and full-time employees over the prior calendar year?

(Used to determine Coordination of Benefits for members 65 and older)

What is the total number of FTE employees* over the prior calendar year?

(Used to determine if Small or Large Group)

Are more than 50% of your enrolled employees within the MVP service area? ☐ **Yes** ☐ **No**

Contact your broker or MVP Account Representative if you are unsure which states and counties are covered within the MVP regional service area.

*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.

Section 3: Separate Entities with Multiple Tax ID Numbers

Only complete this Section if this circumstance applies to the Group recertifying. 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.

If any of the following 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).

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**

Group Name *Group No.*

Section 4: Group Addresses and Contacts

Physical Street Address | City | State | Zip Code

County | Phone No. ( )

Mailing Street Address ☐ Same as Physical Address | City | State | Zip Code

County | Phone No. ( )

Health Benefits Administrator Name | **Health Benefits Administrator** Email

Billing Contact Name | **Billing Contact** Email

Broker/Agency Name

Additional Business Locations

Include all business locations not listed above, including any located outside of New York State.

Street Address | City | State | Zip Code

County | Phone No. ( )

Street Address | City | State | Zip Code

County | Phone No. ( )

Section 5: MVP Vision Plan Attestation

If your group is enrolled in an MVP Vision plan and MVP Vision plan(s) are offered with non-voluntary rates, you attest that the employer contribution is 80% or more to the Vision plan premium.

Employer Initials

Group Name *Group No.*

Section 6: Authorization

For a group health plan to be considered a "group health plan" under the Employee Retirement Income Security Act (ERISA), there must be at least one common law employee enrolled as a contract holder. Pursuant to 29 CFR 2510.3-3(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. 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 Health Care 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 17.5 hours per week or are otherwise eligible for coverage.	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 five thousand dollars and the stated value of the claim for each such violation.	Employer Initials

Employer Signature *Date*

Employer Name (print) *Title*