

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

Total Number of Part-Time and Full-Time Employees Over the Prior Calendar Year <i>(to determine Coordination of Benefits for members 65 and older)</i>	<input type="text"/>
Total Number of Full-Time Equivalent Employees ¹ Over the Prior Calendar Year <i>(to determine if Small or Large Group)</i>	<input type="text"/>

Note: Retirees and COBRA participants are not considered “employees” and should not be counted to determine group size.

¹ The full-time equivalent (FTE) employee counting method in 26 U.S.C. 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.

To convert the number of part-time employees to a full-time equivalent, 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.

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)

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/These groups are owned by another entity.
- This group owns 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	<input type="checkbox"/> Same as Mailing Address	City	State	Zip Code
County	Phone No. ()	Email Address		

<i>Group Name</i>	<i>Group No.</i>
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Section 5: Health Benefits Administrator and Broker Information

Health Benefits Administrator Contact Name	Billing Contact Name
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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 17.5 hours per week or are otherwise eligible for coverage.

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

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