ConnectiCare

Employer Group Size Certification

Group Name: _____ Group Number: _____

Group Renewal Date: ____ /____ /_____

Total Number of Full-Time and Full-Time-Equivalent Employees: ☐ (REQUIRED)

This counting method pertains to the ACA requirement that employers of 51+ offer a qualified health plan with minimum essential coverage. ConnectiCare will use the number of employees from this calculation to determine the product options available to you for the upcoming plan year (Small or Large group). IRS regulations provide detailed rules about this method of calculation; please consult your tax or legal adviser. The following is a **general** description:

The number of employees is determined by adding (1) and (2) below:

1. The number of full-time employees. Full-time is someone employed an average of at least 30 hours per week or 130 hours per month.
2. The number of full-time equivalents (FTEs), which is a combination of employees. An individual employee may not be full-time because he/she is not employed an average of at least 30 hours per week. But in combination, such employees are counted as the equivalent of a full-time employee. *For example, two employees who each work 15 hours per week make up one FTE.* You can also calculate FTEs by aggregating hours worked by non-full-time employees in a month and dividing by 120.

- To determine group size, look to the size of your workforce in the **prior** calendar year.
- Affiliated employers with common ownership or those under common control must aggregate their employees for purposes of determining group size.
- All employees are included for counting purposes—for example, union and non-union employees, employees who are covered by another carrier, employees who have waived coverage, or employees located in other states.
- The IRS regulations have some special counting rules, such as those for seasonal workers, employees whose hours are difficult to track or whose hours vary, school employers, and companies not in existence in the prior calendar year.

I certify that the foregoing information is true and complete to the best of my knowledge and belief. I understand that false or incomplete responses or statements may result in cancellation or rescission of coverage. ConnectiCare reserves the right to request any reasonable documentation from firms, subscribers or dependents in order to verify eligibility. **Rates may be subject to change depending on the certified eligibility information.**

Employer Name: _____ Employer Signature:_____ Date: ___ /___ /_____

Please fax this recertification statement and applicable quarterly wage report to: (860) 678-5272.

Or mail to: ConnectiCare Small-Group Administration Department, 175 Scott Swamp Road, P.O. Box 4050, Farmington, CT 06034-4050. If you have any questions, please call 1-800-723-2986.