Employer Information Form

Employer Name (legal) **& DBAs:**	**Customer/Group #:**	**Federal Tax ID #:**
Nature of Business (products sold / service provided)**:**	**Email Address:**	**Telephone #:**
Current Administrative Location of Your Business (if multiple locations, please list all locations):	**Billing Address:**	

Type of Business Organization (check box below):

☐ Sole Proprietor ☐ S-Corp. ☐ C-Corp. ☐ LLC ☐ LLP (Partnership) ☐ Farm ☐ Non-Profit Corp.

1. Is the group continuing to meet the contribution guidelines defined in your benefit contract? (circle one)

YES / NO

2. Do you file a consolidated tax return as an affiliated group? (circle one) If yes, please provide the most recent **Form 851**.

YES / NO

3. Is your group a Professional Employer Organization (PEO), Employee Leasing Company (ELC), or other such entity that is a co-employer, with your client(s), of client-site employee(s)? (circle one)

YES / NO

If you answered yes, then by signing this form, you agree with the certification in this section: I hereby certify that my company is a PEO, ELC, or other such entity and that only those employees who are the corporate employees of my company, and not my co-employees, are permitted to enroll in this group policy. I understand that Healthfirst will not cover the co-employees under this group policy.

We require **the most recent copy** of your state **Quarterly Wage and Tax Report (QWR). Next to each employee listed on the QWR, please indicate the following:**

- State of residency
- Status code (from the list below)
- Date of hire or termination date (if applicable)

The submitted documents **must identify all employees, owners, partners and contracted employees** of your business, **not only those who have coverage with Healthfirst and/or its affiliates**

If your company does not file a Quarterly Wage and Tax Report (QWR) or you have employees or owners who are not listed on the QWR, please submit the following tax documentation where applicable:

- Sole Proprietorship – IRS Schedule C (Form 1040) or Schedule F (farms)
- S-Corporation – IRS Schedule K-1 (Form 1120S)
- C-Corporation – IRS Form 1120 (pgs. 1-2), including Schedule E and Schedule K #5
- Partnership / LLP – IRS Schedule K-1 (Form 1065) LLC – Appropriately filed IRS schedule(s)
- Non-Profit – Most recent quarter federal Form 941 and current two-week payroll
- New Hires – Most recent two-week payroll report

Status Codes

A	Employee is actively enrolled (plan subscriber).	**S**	Employee is covered under spouse's employer plan.
M	Employee is covered under Medicare.	**O**	Employee has other coverage. Specify nature of coverage (e.g., individual, group, military, parental, etc.)
T	Employee is terminated (no longer works for this employer).	**D**	Employee is declining coverage (i.e., due to cost or doesn't want). Only use this code if the employee is full-time with no other coverage or waiver reason.
P	Employee is part-time and works less than the required full-time hours (includes temporary and seasonal employees).	**L**	Employee is not actively working due to Leave of Absence or other reason. Please provide the last tax form or payroll the employee is listed on.
W	Employee is full-time but is in the policy's waiting period. Indicate date of hire and date the employee will be eligible for coverage.	**C**	Person is covered under state or federal (COBRA) continuation law. Indicate continuation start date and whether coverage is provided by a prior employer or by your company.

THE UNDERSIGNED EMPLOYER, OR DULY AUTHORIZED REPRESENTATIVE, CERTIFIES THAT THE FOREGOING INFORMATION IS TRUE, CORRECT AND COMPLETE TO THE BEST OF HIS/HER KNOWLEDGE OR BELIEF, AND FULLY UNDERSTANDS THAT ANY FALSE STATEMENTS OR FAILURE TO PROVIDE ALL AVAILABLE INFORMATION MAY CONSTITUTE THE BASIS FOR TERMINATION OF COVERAGE AT THE OPTION OF THE INSURER AND/OR THE GROUP POLICY'S ADMINISTRATIVE REPRESENTATIVE.

Name & Title (please print):	Signature:	Date:

Common Ownership Certification

Please complete, sign and submit the Common Ownership Certification.
Renewing Groups- <u>complete and return even if you do not have multiple companies</u>.
Please list all companies that are eligible to be included as part of a consolidated federal tax return (even if they don't file a consolidated federal tax return) or who are part of a controlled group as defined under the Internal Revenue Code.

Customer Name: _____

Group Number (if renewal): _____

Primary Business Location: _____

Business Name:	Federal Tax ID #:	# of Eligible:	On This Policy:
1. _____	_____	_____	Yes / No
2. _____	_____	_____	Yes / No
3. _____	_____	_____	Yes / No
4. _____	_____	_____	Yes / No
5. _____	_____	_____	Yes / No
6. _____	_____	_____	Yes / No

Please check one of the following:

☐ I certify that my business applying for coverage with Healthfirst is not part of a controlled group (commonly owned or affiliates) as defined under the Internal Revenue Code.
Or

☐ I certify that my business(es) applying for coverage with Healthfirst (1) is eligible to file a consolidated federal tax return or (2) meets the IRS test for being a controlled group under common control. I further certify there are no other affiliated entities, other than the ones listed above, who are part of the controlled group that includes my business.

I represent that, to the best of my knowledge, the information I have provided is accurate and truthful. I agree to notify Healthfirst in the event of a change in any of the information that is the subject of this certification. I understand that any misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, an increase in premiums retroactive to the policy date, or other consequences as permitted by law.		
Name (please print) & Title:	Signature	Date:

Summary of Instructions for Responding to Eligibility Verification Audit

☐ Read your cover letter in its entirety.

☐ Complete, sign, and submit the Employer Information Form.

☐ Submit the most recent copy of your state Quarterly Wage and Tax Report that lists **all** of your active employees.

☐ If there are employees enrolled in the plan who are not listed on the Quarterly Wage and Tax Report, please submit the following:

New hires: appropriate tax documents include a payroll report with the new hire(s) listed.

Owners: appropriate tax documents include Schedule K-1 or Schedule C.

☐ If the owner(s) is not identified on the state Quarterly Wage and Tax Report or if you do not file a Quarterly Wage and Tax Report, you must include the owner(s) tax documentation in your response. All owners must be identified and waiver reasons given for those not enrolled in the policy. If there is more than one owner you must include all K-1s accounting for 100 percent of all ownership.

☐ Directly on your state Quarterly Wage and Tax Report, next to each name, you must indicate the status of each employee using the codes provided on the Employer Information Form. If any employee is not covered by the plan, you must indicate why the employee is not enrolled using the status codes provided on the Employer Information Form. Make sure that all employees have been accounted for.

☐ Send all required information, including the Employer Information Form and supporting tax documents, by email to **SMGVerification@Healthfirst.org. We must receive the appropriate and complete documentation from you by the due date on your letter or your group's coverage will not be renewed.**

Frequently Asked Questions

1. **I have never before received a request for this type of information. What is this for?**
   We are verifying that eligibility guidelines and requirements are being met as defined in your group policy.

2. **What are the guidelines I need to meet?**
   Please refer to your group policy, underwriting or contact your agent for more information.

3. **I have a small group [or] I am the owner and have no employees. Do I still need to fill this out as it does not apply to me?**
   Yes. If you are a small group business, this does apply to you, and you are required to respond.

4. **What if I have received an earlier request for this information and I have already responded?**
   It can take up to five business days to process your information once we receive it. Our system may still have shown that your group had not responded or was in an incomplete status. After your information has been processed, we will send you a decision letter indicating the results of the audit. We will also notify your broker, by email.

5. **What if I am not comfortable sharing the wages and Social Security numbers of my employees?**
   In order to prove full time employment based on federal/state wage and hour laws, we must be able to document earnings. If you prefer, you may black out part of the Social Security number (SSN) but leave at least the last four digits visible. Remember, Healthfirst is legally obligated to protect the privacy of your information. The SSN will only be used to validate eligibility.

6. **Why did I receive a notice of non-renewal, when I have already received my renewal packet?**
   The Eligibility Verification Audit is separate from your regular renewal process. The audit must be processed and approved in order to prevent cancellation of your policy. If we cannot confirm your eligibility requirements, the renewal information that you received will become invalid.