ACCOUNT SIZE VERIFICATION FORM

ACCOUNT INFORMATION

Account Name _____

Doing Business As _____

Account Number _____ Renewal Month/Year _____

ACCOUNT SIZE VERIFICATION

Please check the box indicating your group size based on the definitions below and provide your company's total # of full-time equivalent (FTE) employees.

☐ Account Size Is **Large** (Total FTE employees is **greater than 100 over the previous calendar year**)
Total # of FTE employees: _____

☐ Account Size Is **Small** (Total FTE employees is **between 1-100 over the previous calendar year**)
Total # of FTE employees: _____

Note: Upon your upcoming effective date, you must have at least one common law employee who is not the sole owner of the business or the spouse of the sole owner of the business. For more information please visit: https://www.irs.gov/businesses/small-businesses-self-employed/employee-common-law-employee

For more information about calculating group size, visit: https://www.dfs.ny.gov/consumers/small_businesses/small_group_expansion_faqs

Total Number of Employees: _____ (over the previous calendar year)

Required by CMS for Medicare Secondary Payer reporting. More information can be found here - https://www.cms.gov/medicare/coordination-benefits-recovery/mandatory-insurer-reporting-group-health-plans

ADDITIONAL ACCOUNT INFORMATION

Do you offer other carriers? ☐ Yes ☐ No If Yes, please specify _____

☐ Please check here if your business is not subject to ERISA

For more information about ERISA, visit: https://www.dol.gov/general/topic/health-plans/erisa

I certify that all the information furnished on this form is current, true and complete to the best of my knowledge and I have read and agreed to this statement and that I have authority to sign on behalf of the abovenamed group. 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 subject to a civil penalty not to exceed $5,000 and that stated value of the claim for each such violation. I understand that Independent Health, reserves the right to request additional information prior to approving my application for insurance. I understand that Independent Health may conduct an audit to ensure compliance with laws and regulations regarding sale of insurance to small groups, if there is an audit, we may be required to provide verification of the information submitted on this form.

Account Administrator's Signature: _____ Fax #: _____

Account Administrator's Name (print): _____ Date: _____

Account Administrator's email address (please print): _____

Please fax the completed form to (716) 250-7125 **OR** Email to: Sales.Administration@Independenthealth.com

If you have any questions or require additional information, please call (716) 631-5392 or 1-800-453-1910, option 4, to reach a member of our Sales Department.