AULTCARE

ANNUAL DETERMINATION OF GROUP SIZE DEMOGRAPHICS

Employer Name / Legal Name of Company	
Group Number	Employer Identification Number (EIN/TIN)

1. RELATED EMPLOYER ANALYSIS

Does the attached **Related Employer Analysis** define your company as part of a controlled group or affiliated service group?
☐ Yes ☐ No

a. If yes, list the other Related Employer name(s):_____
b. If yes, consider that fact when answering all of the questions below.

2. GROUP SIZE FOR A FULLY INSURED PLAN OFFERING UNDER OHIO LAW*

For **Ohio-based employer plans**, provide the number of employees in the preceding calendar year that worked at least 30 hours during a normal work week? (Note: If your answer is between 2 to 50 employees, you will be offered a Small Group or MEWA plan option.) _____
*Self-funded plans or employers outside Ohio may skip this question.

3. CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA) ANALYSIS

To determine the appropriate continuation of coverage (**COBRA** vs State Continuation) provide the following counts for **50% of the typical business days in the previous calendar year**:

Full-time _____ Part-time (Each is counted as a fraction of a full-time employee.) _____

Total number of employees _____

4. MEDICARE SECONDARY PAYER (MSP) ANALYSIS

a. Did you (including all Related Employers) **have 100 or more** full-time, part-time, seasonal employees or partners on **50 percent or more of your business days** during:
The current calendar year? ☐ Yes ☐ No The preceding calendar year? ☐ Yes ☐ No

b. Did you (including all Related Employers) **have 20 or more** full-time, part-time, seasonal employees, or partners **for each working day in each of 20 or more calendar weeks** (weeks do not have to be consecutive) during:
The current calendar year? ☐ Yes ☐ No The preceding calendar year? ☐ Yes ☐ No

If you checked "Yes" for the **current calendar year, and the 20-employee threshold was met during the current year**, provide the date:_____.

I understand AultCare is relying on my answers to the above questions to ensure overall compliance for my group health plan. I also understand the information submitted will be used to determine: whether Medicare will be the primary payer of claims for my Medicare-eligible insured(s), employer size for continuation of coverage, and employer size status under State and Federal regulations. I certify the answers are true to the best of my knowledge and belief. I also understand I am responsible for promptly notifying AultCare (as indicated above) if my answers to any of these questions change because our organization has increased or decreased the number of employees. I understand that CMS penalties may apply.

Signature of Company Officer or Authorized Representative	Print Name
Title	Daily Contact Email Address
Date	Executive Email Address

Return to: AultCare Insurance Company
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